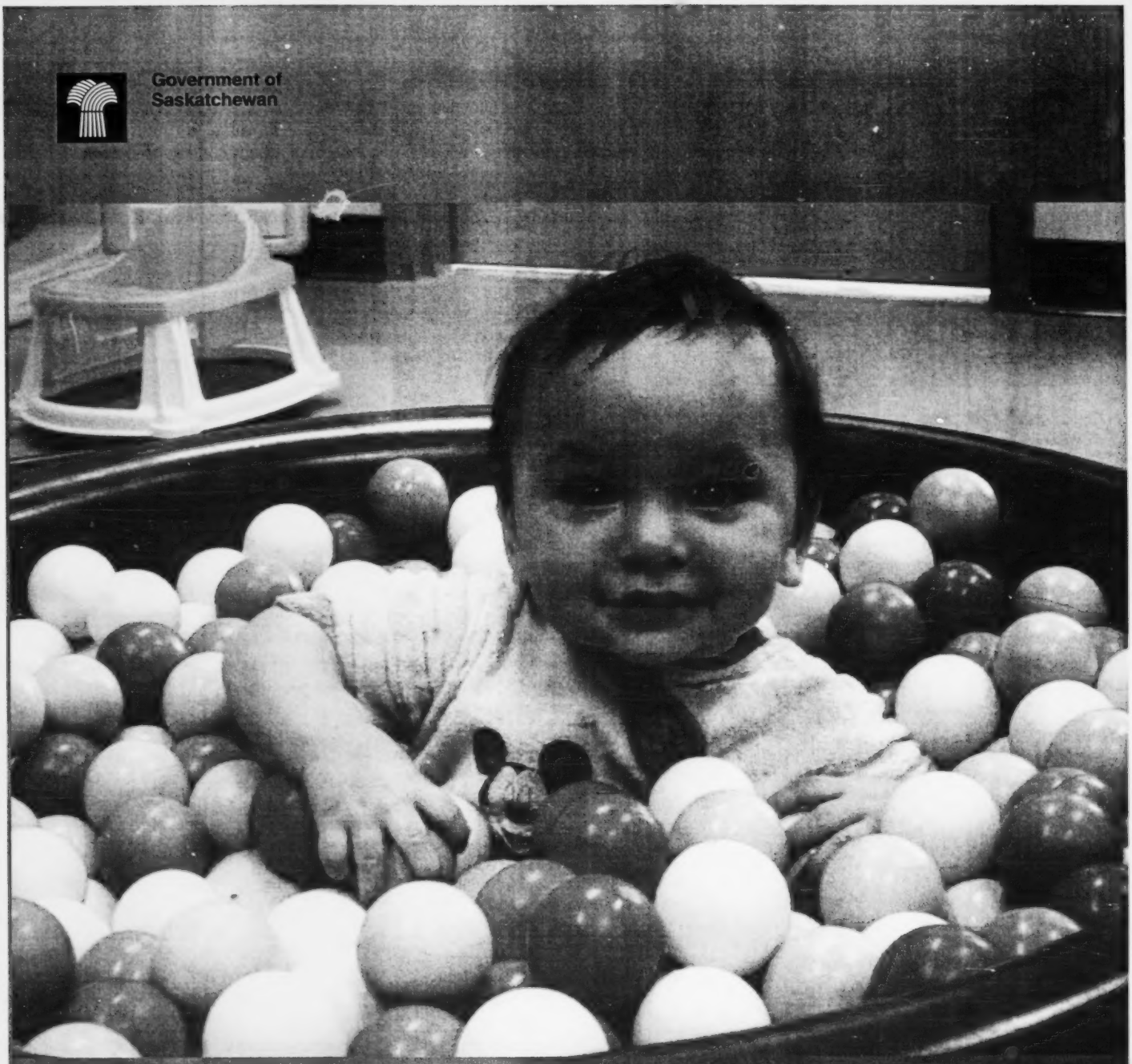
Government of Saskatchewan



Securing Our Future

Early Childhood Development Progress Report 2006/2007

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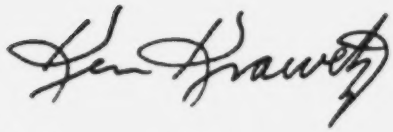
Securing Our Future: Early Childhood Development Progress Report 2006/2007
ISBN # 978-1-897211-35-9
Saskatchewan Ministry of Education, 2008

Message from the Ministers

Providing support to children in the first five years of their lives lays the groundwork for a solid foundation for years to come. Children who grow and thrive on all levels including physical, intellectual, social, emotional and spiritual have a strong base to draw on for the rest of their lives.

Saskatchewan families work hard every day to build a more secure future for themselves and their children. This progress report documents how early childhood development plays a vital role in securing bright futures.



Ken Krawetz
Minister of Education

Don McMorris
Minister of Health

Donna Harpauer
Minister of Social Services

Early Childhood Development Overview

Saskatchewan's *Early Childhood Development Progress Report 2006/2007* discusses areas of action and expenditure by the Government of Saskatchewan as agreed to in the Communiqué on Early Childhood Development 2000 and the Multilateral Framework on Early Learning and Child Care 2003 with the federal government.

First Ministers signed the Communiqué on Early Childhood Development in September 2000. The agreement committed First Ministers to invest new federal funding for early childhood development in four key areas:

- promoting healthy pregnancy, birth and infancy;
- improving parenting and family supports;
- strengthening early childhood development, learning and care; and
- strengthening community supports.

The provinces and territories agreed to expand and develop new early childhood development programs to address these four key areas, contributing provincial funds as they became available. The First Ministers also committed to publicly report on their progress in improving the well-being of Canada's young children, including biennial indicators. These indicators are contained in this year's report.

In March 2003, Ministers Responsible for Social Services signed the Multilateral Framework on Early Learning and Child Care. They agreed to report annually to Canadians on their progress in improving access to affordable, quality early learning and child care programs and services.

The action areas under the Multilateral Framework on Early Learning and Child Care overlap with the early years and prevention focus of the Communiqué on Early Childhood Development. Progress on programming funded by both agreements is reported in the *Early Childhood Development Progress Report 2006/2007*.

Funding and policy direction is provided by the Ministry of Education, the Ministry of Health, the Ministry of Social Services and the Ministry of First Nations and Métis Relations. Five areas of action are profiled in the 2006/2007 report:

- Early Learning and Child Care;
- Prekindergarten;
- Early Childhood Intervention Program;
- infant mortality risk reduction initiatives; and
- the *KidsFirst* program.

Trends and Issues in Early Childhood Development

Brain development begins soon after conception and continues after birth. The growth of the brain that occurs during the early years allows infants to respond to the environment around them and establishes the brain's neural pathways and learning centres.

The *Early Years Study 2: Putting Science into Action* by Hon. Margaret Norrie McCain, J. Fraser Mustard and Dr. Stuart Shanker is the follow-up study to the *Early Years Study: Reversing the Real Brain Drain*. According to *The Early Years Study 2*, scientists have shown, through photographs of the brain, that extensive development of neuron connections occurs in the first six years of life. Before birth, the brain is made up of billions of neurons, but few connections exist between them. These connections begin to form quickly after birth. The formation of connections is much like the evolution of a roadway — connections start out as simple footpaths and with increased use, change into roads and freeways. On the other hand, the connections that are not well-used die away in the process known as synaptic pruning.

The neural pathways in the brain are formed to carry out specific tasks and develop at different rates, beginning with the parts of the brain that deal with physical abilities and concluding with higher cognitive functioning. The sensing pathways that are involved in sight, hearing, touch, taste and smell are fully developed by the age of four.

The five senses develop first because they are necessary for an infant to begin to understand and react to the surrounding environment. When an infant's five senses are stimulated by positive developmental experiences, this allows the infant to learn about the world.

Since the brain forms in a hierarchical way, brain development at the early stages impacts later development. The pathways for hearing are the foundation for understanding language and then speech.

There are critical periods when the brain develops most fully. For example, the sight centre of the brain must be stimulated in order for an infant to be able to see. This needs to happen early in life in order for that sense to be developed. If the visual cortex is not stimulated within this window, it is very difficult to repair or "learn" later in life. The auditory pathways seem to have similar critical periods.

For certain functions, the human brain is amazingly malleable and able to "learn" new information outside the windows of opportunity. However, encouraging these skills outside of these windows of opportunity is more difficult and much less efficient.

Because we live and work in communities where cooperating and forming relationships is important, the ability to regulate emotion and behaviour is an important part of our society. The ability to cope with life's challenges is controlled by a set of interrelated neural pathways and hormonal systems.

At birth, an infant's brain receives information from the senses — eye contact with a parent, the sound of the parent's voice, touch and smell of a parent. Through nurturing touch, holding, smiling and talking to a baby, a parent stimulates the infant's brain in a positive way. Based on the subtle variations in the parent's response to the infant, the infant recognizes patterns that develop the sympathetic nervous system. The infant associates interactions with others as something that is rewarding and learns to depend on the parent to satisfy their needs.

Unfortunately, not all children receive this positive stimulation. Altering the brain patterns of a child who has not received positive developmental experiences or interactions with a parent is extremely difficult later in life because the child's brain is structurally different. Adults who did not receive positive stimulation as children may be at greater risk of experiencing depression, aggression or substance abuse. In contrast,

early nurturing experiences keep stress at healthy levels and help to develop strong emotional regulatory systems.

(Adapted from Hon. Margaret Norrie McCain, J. Fraser Mustard and Dr. Stuart Shanker, Early Years Study 2: Putting Science into Action, Council for Early Child Development, March 2007).

Brain development that occurs in the early years is linked to a child's future success. Tools to measure what has taken place during the early years — children's intellectual, emotional, physical and social development — have begun to inform public policy and social planning. Three of these tools are the Early Development Instrument, the Early Years Evaluation and the Quebec Longitudinal Study of Child Development.

The Early Development Instrument (EDI) is a population-based measure of children's readiness to learn. The tool was developed by the Offord Centre for Child Studies at McMaster University, in collaboration with community stakeholders. Currently, the EDI is the most widely administered early development measurement tool in Canada. Ontario, British Columbia and Manitoba administer the tool provincially and it is also the tool administered and mapped in conjunction with federal Understanding the Early Years projects. It looks at learning readiness in groups of children in five areas:

- Physical health and well-being. eg: Is the child healthy, independent, ready each day?
- Social competence. eg: Does the child play, get along with others, share, exhibit self-confidence?
- Emotional maturity. eg: Is the child able to concentrate, help others, be patient, not aggressive or angry?
- Language and cognitive development. eg: Is the child interested in reading and writing, can the child count and recognize numbers, shapes?
- Communication skills and general knowledge. eg: Can the child tell a story, communicate with adults and children, articulate themselves?

Teachers administer the EDI to each individual child in a Kindergarten class in the first few months of school when children are either four or five years of age. This means that the EDI provides a snap-shot in time of all children in a classroom.

The EDI can aggregate data at the community, regional, or provincial levels. Environment, access to food, medical care, income, housing, parent-child interactions, and involvement in early learning programs impact readiness. School readiness, in this sense, is a proxy for child development and well-being. It also assesses how communities encourage child development.

Many of the trends for school readiness outcomes mirror socioeconomic gradients. However, there are many neighbourhoods that break this trend. In certain communities, where researchers would expect high numbers of children who are not ready for school, there have been higher than anticipated EDI results. Research is needed to examine the protective elements present in these communities. Analysis of these neighbourhoods allows researchers and policy makers to ask further questions about what resources, such as formal learning programs and informal characteristics like community cohesion and strong relationships, exist in neighbourhoods to support the healthy growth and development of young children.

Further information on the Early Development Instrument can be found at www.offordcentre.com/readiness.

The Québec Longitudinal Study of Child Development (QLSCD) identifies factors during early childhood that impact the well-being of children in Quebec. The first phase of data, collected from 1998-2002, looked at the influence of environments on children: family situation, child care and broader social environments. This research was carried out on a cohort of 2,120 Québec infants who were followed annually from five months to about four years of age.

The second phase of the QLSCD (2003-2011) extends the QLSCD 1998-2002. Continuing with this cohort of children allows researchers to gain an understanding of children beginning primary school and the developmental factors that favour academic success in light of children's life experiences in early childhood.

Longitudinal studies by definition look at children's circumstances over the long term. This allows for a large range of questions to be explored. Exploration and evaluation help to inform social and family policies that promote child development.

Research has focused on a variety of areas dealing with overall wellness. These include health, motor, social and cognitive development, behaviour, diet, sleep, the family and economic environment, and use of child care. This has allowed the QLSCD to develop a rich and detailed picture of the young children it has followed. The researchers, students and professionals working on the QLSCD are now pursuing a number of projects that use data collected during the first phase of the study.

Further information on the Quebec Longitudinal Study of Child Development can be found at www.jesuisjeserai.stat.gouv.qc.ca.

The Early Years Evaluation (EYE) is an assessment instrument that allows preschool and Kindergarten teachers to assess each of their students. After assessment, teachers receive reports that allow them to identify children who would benefit from more support or intervention. The EYE tool also serves to inform systems since data can be aggregated to the school and district levels.

The Early Years Evaluation (EYE) was developed for the World Bank as a tool to assess the early years outcomes for children entering school. The tool was developed based on the following ten criteria:

- Easy and inexpensive to administer.
- Examines the five major domains that describe children's development and wellness— general knowledge; behaviour, social development and approaches to learning; cognitive development; language and communication; and physical development.
- Provides feedback to teachers to improve their ongoing classroom practice.
- Includes assessment tasks that can be administered directly to children.
- Involves a range of task difficulty that allows for application in low and high income countries.
- Results can be anchored to other assessment tools, including the EDI.
- Allows for comparisons among communities and longitudinal comparisons for the same communities over time.
- Assesses where individual children may benefit from more intensive supports.
- Builds on development and emerging literacy research.
- Provides results that link directly to social and educational policy.

Further information on the Early Years Evaluation can be found at www.ksiresearch.com/eye.

Early Learning and Child Care

The Early Learning and Child Care Branch transferred from the Ministry of Social Services to the Ministry of Education on April 1, 2006. It was then expanded to incorporate Early Childhood Development and Early Childhood Education. This amalgamation allowed for the majority of programming directed at early learning and child care to be carried out within a single provincial ministry.

In 2005, the Government of Saskatchewan contracted a sector study to assess the impact of the expansion of licensed child care in the province. It assessed training required in the sector and how it could be offered to accommodate the needs of early childhood educators. The results of the study, *ELCC Sector Study: Final Report*, were released in 2006. The study is being used to inform ongoing development of policy and strategic initiatives including the development of the early learning and child care human resources strategy. The human resources study can be found by following the 'Research' link at www.education.gov.sk.ca/ELCC-Program.

The province continued to move ahead with early learning and child care initiatives by prioritizing enhancements based on available resources. The 2006-07 budget provided an additional $7.8 M in incremental funding for the following:

- Developing 250 new child care spaces in the fourth and final year of Child Care Saskatchewan.
- Eliminating the wait list for funding child care supports for children with exceptionally high needs.
- Increasing staff wages in child care centres by 9% effective April 1, 2006 – the third consecutive increase for this sector.
- Increasing Support Services Grants for Teen Student Support Centres.
- Increasing and enhancing child care subsidies by $5.4 M (annualized) effective September 2006.

Prekindergarten

In 1996-97, the Ministry of Education's Prekindergarten program was introduced as a partnership with school divisions that had Community Schools. Since then, the number of programs has grown to 119 in 2006-07.

Additional funding was approved in the 2006-07 provincial budget to provide funding to 15 new Prekindergarten programs. These programs were located in the following schools:

- Battleford Central School, Battleford
- Sydney Street School, Maple Creek
- Westmount School, Moose Jaw
- John Diefenbaker and W.J. Berezowski Schools, Prince Albert
- Judge Bryant, Dr. Hanna and St. Peter Schools, Regina
- Rosthern Elementary, Rosthern
- Princess Alexandra, Vincent Massey, Howard Road, St. Maria Goretti and St. Mark Schools, Saskatoon
- Shaunavon Public School, Shaunavon[1]
- St. Patrick School, Swift Current[1]

Individual Prekindergarten programs enrol up to 16 three- and four-year olds in half day sessions, four or five times a week. The program is developmentally appropriate and incorporates elements to meet the needs and circumstances of the children and families involved in the program.

Specifically, early intervention Prekindergarten focuses on:

- Fostering social development and self esteem.
- Nurturing educational growth and school success.
- Promoting language development.
- Engaging families.

Family engagement is a key goal for the Prekindergarten program in Saskatchewan. When parents are involved in learning, the benefits to children include improved cognitive functioning and greater school success. Teachers benefit from collaboration with parents and parental insights about their child.

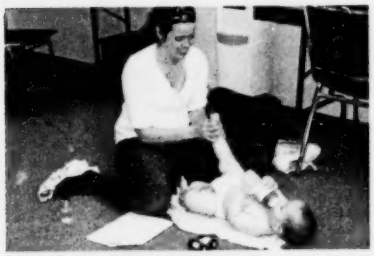
Targeted Prekindergarten programs involve families directly in the classroom and in organized parent-child activities. Teachers visit with parents and family members in their homes and families have the opportunity to participate in family education programs.

Additional support services that may be offered through Prekindergarten include: transportation, speech and language, nutrition, dental and public health, family literacy, music, and swimming programs.

Better Beginnings, Better Futures was developed in 1997 and revised in 2004 as a guide to policy and practise for Prekindergarten programs in the province. It provides a conceptual framework for a high quality early childhood education program within a Prekindergarten. The document provides an overview of the components of a Prekindergarten program, practical considerations in developing a program for young children and discussion about roles and responsibilities for educators, parents, administrators and other community members. The document can be accessed at www.education.gov.sk.ca/PreK.

[1]Shaunavon Public and St. Patrick schools both implemented a program but shared a Prekindergarten operation grant.

Infant Mortality Risk Reduction Initiatives



Infant mortality rates in Saskatchewan, Canada and other developed countries have decreased significantly in the last 100 years. In 1985, the infant mortality rate in the province was 11.0 per 1,000 live births. The provisional Saskatchewan infant mortality rate in 2006 was 6.4 infant deaths per 1,000 live births. Although the infant mortality rate in Saskatchewan has dropped over the last two decades, Saskatchewan remains higher than the Canadian average.

The Ministry of Health funds direct interventions in the province's highest risk health regions.

Prenatal and Postnatal Nutritional Support for Vulnerable Mothers

In 2006-07, the Ministry of Health continued funding the two Northern health regions, Keewatin Yatthé and Mamawetin Churchill, to provide prenatal nutritional support to vulnerable women. This support increases their knowledge and skills around health and nutrition during and after pregnancy.

Interventions focus on: prenatal, infant and general nutrition; food preparation; economical shopping for healthy foods; breastfeeding; and alcohol and smoking avoidance. These supports are available in five communities which do not have access to the federally funded Canadian Prenatal Nutrition Program and include Cole Bay/ Jans Bay, Stony Rapids and area, Buffalo Narrows, Sandy Bay and Pinehouse Lake.

In 2006-07, the following seven additional communities benefited from these nutritional projects: Sled Lake, Dore Lake, St. George's Hill, Michel, Weyakwin, Uranium City and Camsell Portage.

Targeting Risk Factors for Infant Mortality

In order to reduce infant deaths and enhance perinatal-infant health province-wide, the Ministry of Health funds the Perinatal Infant Health Program delivered by the Saskatchewan Prevention Institute.

This work focuses on the following key areas:

- Increasing the depth of knowledge about factors that contribute to infant deaths such as infant care practices, Sudden Infant Death Syndrome, preterm birth, congenital anomalies, etc.
- Raising awareness among parents, professionals, service providers and others about the major causes of perinatal and infant mortality.
- Facilitating forums to discuss factors contributing to perinatal and infant mortality and ways to reduce it.
- Building on existing partnerships and networks to enhance collaborative efforts in the areas of perinatal and infant health.

Early Childhood Intervention Program

The Early Childhood Intervention Program (ECIP) is a province-wide network of community-based supports to families with children from birth to school age who experience or are at risk for developmental delays. ECIPs work to enhance child development, support families and enhance community networks.

The local and provincial ECIP organizations share the vision, "All families have the capacity to meet the developmental needs of their children within the community of their choice."

Children who are involved with ECIPs are often delayed in reaching age-appropriate developmental milestones such as walking, talking, eating, manoeuvring, playing or interacting socially. They may also be born with a condition or diagnosis that makes it more difficult for them to develop at rates that are typical for a specific age group. ECIP interventionists build trusting relationships with families and assist them in working toward mutually-identified goals for their children and family.

ECIP staff provide an important link between families and other professionals. They work collaboratively with child care providers, speech and language pathologists, physiotherapists, occupational therapists, nurses, physicians, early childhood psychologists, teachers and school administrators, among others, to support achievement of family-centred goals. They also support smooth transitions to school and other centre-based programs and services as needed.

ECIP Goals

- Children will experience an enhanced quality of life.
- Families will parent with increased effectiveness.
- Families' confidence to advocate for their children who experience, or are at risk for, developmental delays will be enhanced.
- Communities will become more inclusive.

ECIP Highlights 2006/2007

- Ile-a-la-Crosse - Wecihik Awasisak (Help the Children Inc.) provided services to 28 children and their families.

- Kindersley - West Central Early Childhood Intervention Program Inc. provided services to 29 children and their families.

- La Ronge — Children North Early Childhood Intervention Program Inc. provided services to 88 children and their families.

- Lloydminster — Midwest Family Connections provided services to 42 children and their families.

- Meadow Lake — Meadow Lake & Area Early Childhood Services Inc. provided services to 84 children and their families.

- Moose Jaw — South Central Early Childhood Intervention Program Inc. provided services to 48 children and their families.

- North Battleford — Battlefords Early Childhood Intervention Program Inc. provided services to 128 children and their families.

- Prince Albert — Prince Albert Early Childhood Intervention Program Inc. provided services to 102 children and their families.

- Redvers — South-East Early Childhood Intervention Program Inc. provided services to 45 children and their families.

- Regina — Early Childhood Intervention Program, Regina Region Inc. provided services to 140 children and their families.

- Saskatoon — Saskatoon Region (Alvin Buckwold/Prairie Hills) Early Childhood Intervention Program provided services to 98 children and their families.

- Swift Current — Swift Current & District Early Childhood Intervention Program Inc. provided services to 59 children and their families.

- Tisdale — North East Early Childhood Intervention Program Inc. provided services to 48 children and their families.

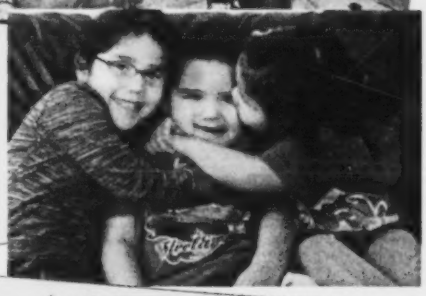
- Weyburn — Weyburn & Area Early Childhood Intervention Program Inc. provided services to 44 children and their families.

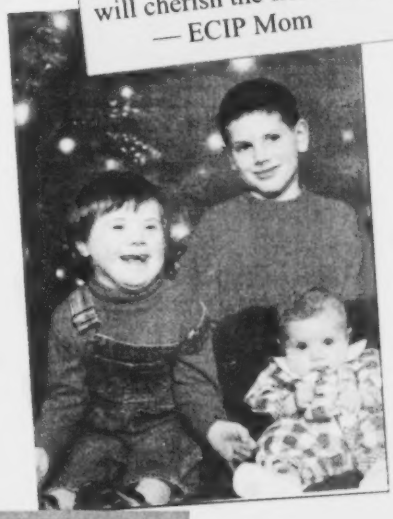
- Yorkton — Parkland Early Childhood Intervention Program Inc. provided services to 63 children and their families.

An ECIP Story ...

It's too bad that the Book of Life doesn't come with a first draft so you can edit out the bad and double the good. But life doesn't work that way and for our family, we certainly didn't choose to have a chapter on Rett Syndrome included in our lives. Life is more than what you are handed ... it's what you do with what is placed in your hands. When we heard the words 'Rett Syndrome' for the first time, it brought us much confusion, sadness, devastation, anger, guilt and hurt. As time went on, we did learn that the physics of happiness do not require perfection and performance—only acceptance and love. This awareness does not come easily. We met hurt after hurt, challenge after challenge and crisis after crisis. We did learn that the big things in life really are, after all, the little things. One has to learn to change what we can, accept what we can't, and go on. In our family life, we have gained so many valuable insights and have gathered so much courage. At the same time, we have learned the true meaning of unconditional love and the power of patience and understanding, thanks to our special daughter. She may not walk on her own, yet she helps us walk taller. As she struggles to move, she moves many hearts. She may need to be fed, yet she feeds our spirits. She may not speak to us in words, but she speaks to us in so many ways in the silent language of love. She brings many blessings to us—one being bringing ECIP into our lives. Our many home visits with our ECIP worker brought our family hope, strength, knowledge and an abundance of support. Her guidance on "the road to Rettland" made it easier to travel on. Our family is so grateful for the positive attitude ECIP brought into our lives and we will cherish the friendships forever.

— ECIP Mom





An ECIP Story ...

Our family became involved with the ECIP program in 2001 when our second child was born with Down Syndrome. ECIP was a lifesaver! They came for a visit every two weeks to assist our son with exercises, games, and stories to help encourage his development in all areas. I'm not sure who enjoyed the visits more! I know he was always excited to see that toy box coming through the door. I appreciated the sympathetic ear of the early interventionist who came for the home visits, especially if I had been having a rough day or week and really needed to vent. I can't say enough great things about the program, and the caring helpful staff. They will certainly not be forgotten!

— ECIP Mom

KidsFirst

Announced in April 2001, *KidsFirst* is an interministry initiative designed to support families to nurture their children, prenatal to age five. The program focuses on providing prevention and early intervention services to families living in vulnerable circumstances.

The *KidsFirst* Strategy is comprised of two program streams: intensive services targeted in nine communities; and Regional *KidsFirst* Early Childhood Community Developers who work with stakeholders and partners to strengthen early childhood services across the province.

Intensive *KidsFirst* services are offered in Meadow Lake, Moose Jaw, Nipawin, the entire North, North Battleford, Prince Albert, Regina, Saskatoon and Yorkton. Each targeted *KidsFirst* site receives local guidance from an intersectoral Management Committee. Membership includes representatives from regional Social Services offices, health authorities, school divisions, regional Education offices, Regional Intersectoral Committees, community partners and First Nations and Métis communities.

Day to day program operations for intensive *KidsFirst* services are coordinated by a program manager, who reports to the Management Committee and liaises between the program components and community partners. Delivery of services is carried out through community-based organizations. As a result, *KidsFirst* acts as an umbrella organization that has built on existing resources in the community.

Services under the *KidsFirst* banner are delivered in each community by a variety of organizations with expertise in a given area. Key partners may include Aboriginal Head Starts, tribal councils, Métis service agencies, Open Door Societies and other local service agencies. The partnership model allows for a diverse range of services that reflect local demographics and access to services in the neighbourhoods where *KidsFirst* families live.

Families also have the opportunity to participate in the full range of programs offered by each community-based organization. For example, a *KidsFirst* family may first be introduced to an organization through their home visitor and later participate in a home safety or family literacy program. This encourages families to build social networks in ways that are comfortable for them and to select services that will benefit them the most.

KidsFirst services include:

- *Prenatal services* — working with pregnant women to ensure they have the healthiest pregnancy possible, including receiving proper nutrition or nutritional supplements, prenatal education, medical care, and access to mental health and addictions services.

- *In-hospital birth questionnaire* — after the birth of a child, Saskatchewan parents are asked a series of questions about their health and family situation.

Responses to these questions give service providers information to link families to early childhood development services available in their community. Aggregated data provides information about families with new babies at regional and provincial levels.

- *In-depth assessment* — families participate in order to assess their current circumstances. This allows service providers to focus efforts for maximum benefit. The information also provides baseline data for new *KidsFirst* families.

- *Home visiting* — this is the cornerstone of the *KidsFirst* program. *KidsFirst* uses a lay or mentor model of home visiting. Home visitors work with families to promote child development and parent-child interactions. Families are also supported by supervisors and the mental health and addictions team. Home visitors work with families on family-identified goals, such as going back to school, finding a job, or becoming a better parent. Home visitors encourage a family's confidence so the family can eventually 'graduate' from *KidsFirst*. They also provide practical support and advice in areas like arranging for transportation, child care, medical or professional appointments or job readiness training.

- *Early learning opportunities* — children participate in community-based opportunities to support their social, cognitive, physical and emotional development.

- *Access to child care* — enables families to participate in skills training and the work force, as well as providing a positive learning environment that maximizes development occurring during a child's early years.

- *Dedicated mental health and addictions services* — assist families through creative outreach.

- *Community-based supports* — these enhance family knowledge and social networks through literacy programs, child development skills, nutrition education, skills training, parenting education and family activities.

In 2006-07, 777 new families began participating in *KidsFirst*. On March 31, 2007, there were 1,043 families enrolled and participating in *KidsFirst* services. Communities focused on enhancing quality and access to early learning and child care arrangements, strategic planning for community projects and working with the Ministry of Social Services to recommend changes to the province's income assistance programs to more closely match the needs of pregnant and post-partum mothers.

Provincial meetings at the program manager level allow sites to share local knowledge and strategies. It is also the forum to discuss policy and standards for all *KidsFirst* programs in the province. Topics included: defining an evaluation framework; reviewing and updating the protocol describing roles and responsibilities when families are involved in both *KidsFirst* and Child Protection Services; developing a provincial parent satisfaction survey to determine the level of parental satisfaction with *KidsFirst* services; and standardizing data collection.

A *KidsFirst* Story ...

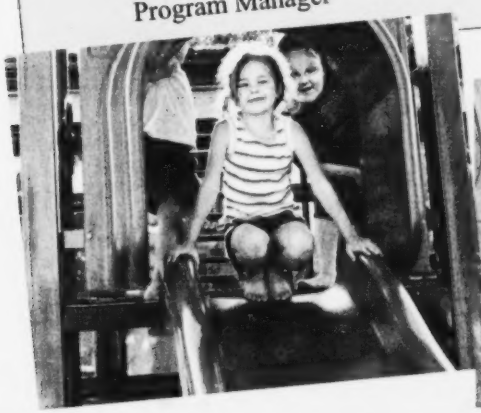
Two La Ronge *KidsFirst* North moms and one from the community of Pinehouse Lake graduated from the Grade 12 program at Northlands College in June 2006. Both La Ronge moms have been *KidsFirst* North families since the beginning and have overcome many struggles. Both have completed their Grade 12 and have plans to move on to further education, one as a youth worker and the other plans to enter an office education course. The Pinehouse Lake graduate has plans to further her education in La Ronge in the fall.

— *KidsFirst* Home Visitor

A *KidsFirst* Story ...

National Child Day activities were held in La Ronge at the Kikinahk Friendship Centre on November 20, 2006. Festivities included a blue ribbon campaign to recognize National Child Day, Christmas crafts, children's races, fish pond, piñata, door prize draws and a child identification clinic. Everyone had lots of fun and the event was a huge success. It takes a lot of work to host these types of events. Partnerships played a big role in the event's success. A big thank-you to all who helped to organize the event — the Teen Young Parent worker, Canadian Prenatal Nutrition Program, Aboriginal Headstart staff, and La Ronge *KidsFirst* North staff members.

— Rebecca Clarke, *KidsFirst* North Program Manager



A *KidsFirst* Story ...

I have seen a mom go from a very angry, stubborn, unemployed young mom living in an almost empty apartment to an outgoing, happy, employed young lady. With the home visitor's help, she was able to find housing through the local Housing Authority. She has found a job, and although she has a lot of difficulty finding child care, she continues to try and work and really enjoys it. This mom now participates in many of the special events held at Kikinahk (her home visiting agency), something she would never have done a year ago. The home visitor is proud of the many accomplishments this mom has made.

— *KidsFirst* North Home Visitor

A *KidsFirst* Story ...

Many moms come a long way in learning how to solve their own problems. In particular, I think about one mom who got herself into a forensics course. She found out she needed her biology 30 so she went to see some people at SIAST and she got bumped up ahead of others because she was already enrolled to take a class. She set up child care arrangements on her own, and asked me to do a referral for transportation. I wished her luck and told her she should be proud of herself for doing so much on her own. When I think about it, this woman has come a very long way from when I first started working with her and she was constantly calling about one crisis after another. Today, she's a different person.

— Prince Albert *KidsFirst* Home Visitor

A *KidsFirst* Story ...

This note is a hello and a thank you, too, for the little goodies you sent our way. My daughter and I enjoyed making a Valentine's Day card with the supplies you sent and we will use the red gloves when she grows into them. We haven't yet gotten into the play dough you made for us but will try to soon … the feel good phrases and other info sheets were good reminders of how to treat one another and how to take care of not only our hearts but our whole bodies!

My daughter is now attending a Pre-K program, we are involved in the Collective Kitchen, and we buy fresh food boxes … we have missed going to the Circle of Learning but we will try to come again soon now that the flu season is over and our kids are better. We are hopefully going to make it back to the Circle one day soon. I miss all the information on child care and parent-child interaction ideas.

We have enjoyed being a part of your program and I am especially thankful for the mentor I have been assigned. She is the most kind, thoughtful and helpful person I have met. She makes me feel good about my struggles as a busy mom and wife. She is so encouraging to me. Thank you everyone at *KidsFirst*!

— North Battleford *KidsFirst* Mom

Regional *KidsFirst* Early Childhood Community Developers

Regional *KidsFirst* Early Childhood Community Developers work with community stakeholders and partners, including tribal councils, First Nations service agencies and Métis Friendship Centres to develop strategies that support vulnerable families and align services. Regional *KidsFirst* Community Developers work towards positive early childhood outcomes and parent-child interactions.

Working within the borders of provincial regional health authorities, they facilitate planning and collaboration around early childhood development. Regional *KidsFirst* Community Developers receive guidance from and work in partnership with a variety of community-based early childhood development services. These include Early Childhood Intervention Programs, school divisions, Regional Intersectoral Committees, parent support programs and public health nurses.

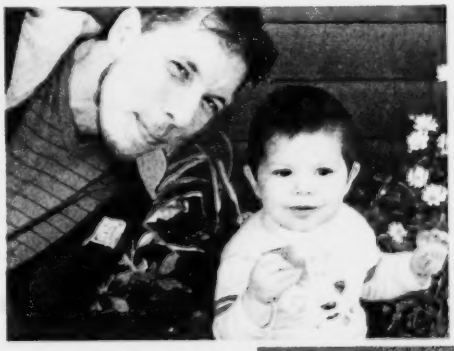
In 2006-07, Regional *KidsFirst* Community Developers focused on the development of provincial strategic priorities. They examined their role within their region's intersectoral human services map. They also built understandings around how their work relates to the provincial *KidsFirst* Strategy and developed a standard reporting template.

The template is based on the *KidsFirst* Strategy. It uses five lenses to assist in the planning of projects and activities the Community Developers undertake. They include:

- How does the initiative benefit children prenatal to age five?
- How does the initiative build on existing supports and services?
- How are you working to make the initiative sustainable?
- How does the initiative build relationships and partnerships at the community level?
- What steps are you taking to ensure the initiative is inclusive of families of diverse backgrounds, cultures and needs?

Although Regional *KidsFirst* Community Developers have diverse roles within their communities, they all work to support and nurture children's abilities to learn. Benefits to the community as a result of this work include:

- Increased knowledge among early childhood educators to enhance preschool children's language development.
- Increased positive family interactions.
- Increased awareness of the benefits of family literacy.
- Strengthened community partnerships focusing on the early years.
- Increased parent knowledge about childhood developmental milestones.
- Improved parent-child relationships.
- Improved supports for child language development.
- Improved referrals and supports for young children and their families.



Year Over Year Investments in Early Childhood Development 2001-02 to 2006-07

The following table outlines actual expenditures from 2001-02 through 2006-07 for the Early Childhood Development Strategy. To the end of 2006-07, expenditures under the Early Childhood Development Federal/Provincial/Territorial Framework Agreement totalled $73.3 M. Federal revenue totalled $84.2 M at the end of 2006-07.

Program Area	2001-02 Actual	2002-03 Actual	2003-04 Actual	2004-05 Actual	2005-06 Actual	2006-07 Actual
KidsFirst						
Regional *KidsFirst* Communities • In-hospital birth questionnaire • Realignment of existing programs	$637,000	$0 [1]	$618,000	$637,000	$648,000	$660,000
Targeted *KidsFirst* Communities • Prenatal screening and outreach • In-hospital birth questionnaire and assessment • Home visiting • Mental health and addictions • Enhanced child care [5] • Early learning programs • Parenting supports	$3,009,000 [2]	$6,754,000	$9,805,000	$11,114,000 [3,4]	$12,300,000 [3]	$12,234,000 [3]
Program Support	$945,000 [4,6]	$590,000 [6]	$677,000 [6]	$1,109,000 [4,6]	$865,000 [6]	$437,000 [6]
Child Care • Training, wage enhancement and start up grants	$1,019,000	$1,019,000	$1,019,000	$1,019,000	$1,019,000	$1,019,000
Early Intervention Spaces	$370,000	$370,000	$370,000	$370,000	$370,000	$370,000
Prekindergarten Program	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000
Infant Mortality Reduction Initiatives [7]	$95,000[4]	$72,000[4]	$0[4]	$50,000[4]	$35,000[4]	$21,000
TOTAL	**$6,275,000** [4]	**$9,005,000**	**$12,689,000**	**$14,499,000** [4]	**$15,855,000** [8]	**$14,941,000**

[1]Expenditures for 2002-03 were expensed in 2001-02.
[2]The figure reported in the *ECD Progress Report 2004 2005* was $3,119,000.
[3]Includes $100,000 provided as additional support under the Cognitive Disability Strategy.
[4]The figures reported in the *ECD Progress Report 2004 2005* were budgeted figures. Figures shown here are actual expenditures.
[5]From 2006-07 forward, funding for enhanced child care was administered through the Ministry of Education's Early Childhood Services grant. *KidsFirst* retained priority access to child care spaces through local Memoranda of Understanding.
[6]Includes training, program tracking and program evaluation.
[7]Figures reflect expenditures on prenatal and postnatal nutritional supports for vulnerable mothers.
[8]Includes $418,000 to establish the Saskatchewan Literacy Commission.

Year Over Year Investments in Early Learning and Child Care 2002-03 to 2006-07

	2002-03	2003-04	2004-05	2005-06	2006-07
Early Learning and Child Care					
Child Care Facilities					
• Number of licensed centres	138	153	158	173	179
• Number of licensed family child care homes	277	291	287	290	276
Total Licensed Child Care Facilities	**415**	**444**	**445**	**463**	**455**
Child Care Spaces					
• Infant spaces	357	452	498	576	609
• Toddler spaces	980	1,129	1,206	1,380	1,430
• Preschool spaces	2,949	3,085	3,162	3,454	3,574
• School-aged spaces	837	874	902	907	935
Total centre-based spaces	*5,123*	*5,540*	*5,768*	*6,317*	*6,548*
• Number of licensed family child care home spaces	2,160	2,370	2,369	2,395	2,302
Total Licensed Child Care Spaces	**7,283**	**7,910**	**8,137**	**8,712**	**8,850**

	2002-03	2003-04	2004-05	2005-06	2006-07
Prekindergarten					
• Number of programs	89 [10]	104 [10]	104 [10]	104 [10]	119 [10]
• Number of spaces	1,300	1,661	1,666	1,664 [11]	1,904 [11]

[10] Includes four programs financed through federal ECD funds serving 66 children.
[11] Based on an estimate of 16 spaces per program.

	2002-03	2003-04	2004-05	2005-06	2006-07
Early Entrance Designated Disabled Pupil Program					
• Number of children	289	307	230	257	294

	2002-03	2003-04	2004-05	2005-06	2006-07
Child Care Subsidy					
• Average number of subsidies	3,353	3,408	3,518	3,375	3,362
• Average monthly subsidy	$239.96	$254.64	$264.70	$283.49	$345.68
Total Child Care Subsidy	$9,665,000	$10,414,000	$11,183,000	$11,482,000	$13,946,000

	2002-03	2003-04	2004-05	2005-06	2006-07
Grants for Child Care Programs					
• Early Childhood Services Grants	$4,441,000[12]	$5,27,000[12]	$5,828,000[12]	$6,988,000[12]	$12,331,000[12]
• Teen Support Grants	$732,000	$873,000	$995,000	$1,027,000	$1,916,000
• Preschool Support Grants	$504,000	$508,000	$508,000	$556,000	$576,000
• Start-up Grants	$153,000 [13]	$206,000 [13]	$142,000	$299,000[13]	$114,000[13]
• Home Equipment / Programming Grants	$129,000 [14]	$134,000 [14]	$150,000 [14]	$157,000[14]	$150,000[14]
• Special Northern allowances	$19,000	—	$39,000	$29,000	$27,000
• Community Solutions Grants *(rural, workplace, special needs, etc.)*	$610,000	$702,000	$857,000	$1,040,000	$1,000,000
• Training / Education Grants	$9,000 [15]	$4,000 [15]	$3,000 [15]	$21,000[15]	$3,000 [15]
• Special Needs Grants	$1,415,000	$1,606,000	$1,684,000	$1,992,000	$2,236,000
Total Child Care Grants	$8,012,000[16]	$9,305,000[16 17]	$10,206,000[16 18]	$12,109,000[16]	$18,353,000[16]
• Capital Grants	—	$417,000	$166,000	$605,000	$176,000
• Child Care Administration *(licensing and subsidy)*	$1,826,000	$2,014,000	$1,933,000	$2,132,000	$3,044,503

[12] Plus $869,000 ECD.
[13] Plus $15,000 ECD.
[14] Plus $50,000 ECD.
[15] Plus $85,000 ECD.
[16] Plus $1,019,000 ECD.
[17] The figure reported in the *ECD Progress Report 2004 2005* was $9,674,451.
[18] The figure reported in the *ECD Progress Report 2004 2005* was $10,321,452.

Indicators of Child Well-Being in Saskatchewan

As part of the 2000 Communiqué on Early Childhood Development, First Ministers agreed to publicly report on child well-being using a common set of indicators. This section fulfills this commitment. For 2006-07, Saskatchewan will report on 21 indicators of child well-being.

Saskatchewan child well-being is either consistent with, or can be favourably compared to the national average in many areas. However, there are some indicators that are of concern. For example, there is a higher incidence of injury hospitalization, tobacco use during pregnancy, and low income rates when compared to the national average. Public health analysts monitoring data have highlighted these concerns for several years. Additionally, reporting does not include children living on reserve. The small sample of Saskatchewan children participating in the National Longitudinal Study of Children and Youth reduces the reliability of Saskatchewan data.

Birth weight — high and low

Weight at birth is used as an international indicator not only of a mother's health and nutritional status, but also the newborn's chances for survival, growth, long-term health and psychosocial development. Low birth weight (less than 2,500 grams) carries a range of health risks for children. Babies who were undernourished in the womb face an increased risk of dying during their early months and years. Those who survive have reduced immune function and increased risk of disease, including higher incidence of diabetes and heart disease as adults. Children born underweight may be at greater risk of developmental delays and poor school performance.

High birth weights have also been implicated as a risk factor of certain diseases. A birth weight of over 4000 g has been linked to: greater complications with child birth; higher rates of caesarean delivery; cancers like childhood leukemia, Wilms tumour and prostate cancer; childhood asthma; type 2 diabetes; and overweight and obesity from childhood to adulthood. While Saskatchewan's high birth weight is above the Canadian average, five of 13 provinces and territories had a greater percentage of high birth weights than Saskatchewan in 2004.

High Birth Weight Rate: % of live births with weight greater 4000 g

	1998	1999	2000	2001	2002	2003	2004
Canada	12.8	13.1	13.8	13.6	13.2	12.8	12.3
Saskatchewan	14.8	14.9	16.1	16.3	16.2	15.9	15.6

High birth weight rate = number of live births weighing > 4000 g / number of live births x 100. The data for high birth weight rates is derived from provincial and territorial vital statistics registries. (Canadian Vital Statistics Birth Database, Statistics Canada.)

Low Birth Weight Rate: % of live births with weight less than 2500 g

	1998	1999	2000	2001	2002	2003	2004
Canada	5.7	5.6	5.6	5.5	5.8	5.8	5.9
Saskatchewan	5.2	5.3	5.1	5.2	5.1	5.6	5.5

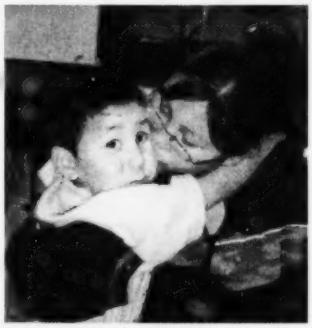
Low birth weight rate = number of live births weighing < 2500 g / number of live births x 100. The data for low birth weight rates is derived from provincial and territorial vital statistics registries. (Canadian Vital Statistics Birth Database, Statistics Canada.)

Immunization

- **Meningococcal disease**
- **Measles**
- **Haemophilus influenza-b (Hib)**

Infectious diseases affect thousands of children each year, although the mortality rate across Canada has declined in recent years due to increased awareness among families and health professionals.

Tracking the incidence of diseases such as measles, meningococcal disease and haemophilus influenza-b provides an indication of outbreaks of these diseases and the effectiveness of immunization practises. It is less effective in comparing differences between jurisdictions. Since 1999, Saskatchewan has had no cases of measles among zero to five year olds, and only one case of meningococcal disease, group C.



Incidence among children 0 to 5 years for three vaccine-preventable diseases

	1999		2000		2001		2002		2003		2004		2005		2006	
	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can
Measles	0	9	0	81*	0	7	0	2*	0	6	0	6	0	2	0	8
Meningococcal disease[1]	1	9	0	18*	0	28*	0	9*	0	5	1	11	0	2	0	ND
Hib	0	15	0	7	1*	13*	0*	13*	2*	7*	2	5	0	7	1	3

Rate per 100,000 among children 0 to 5 years for three vaccine-preventable diseases

	1999		2000		2001		2002		2003		2004		2005		2006	
	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can	SK	Can
Measles	0	0.5	0	3.7	0	0.3	0	0.1*	0	0.3	0	0.3	0	0.1	0	0.4
Meningococcal disease[1]	1.2	0.5	0	0.8*	0	1.3*	0	0.4*	0	0.2	1.4	0.5	0	0.1	0	ND
Hib	0	0.8	0	0.5*	1.6*	0.99*	0*	1.0*	3.3*	0.5	3.3	0.4	0	0.1	1.7	0.2

For measles, invasive meningococcal group C disease ([1]), numbers and rates include children 0 to 5 years of age; for Hib, rates include children 0 to 4 years of age. Data for measles, invasive meningococcal group c disease and Hib for 2002 and 2003 are provisional and subject to change. Hib (haemophilus influenza type b disease) based on confirmed cases reported through the Notifiable Diseases Surveillance System. Hib data not available for Quebec for 2003 to 2006. Overall rate does not include Quebec and Saskatchewan in numerator or denominator. Source: Immunization and Respirator Infections Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada and Saskatchewan Ministry of Health. *Data differs from previous reports.

Infant mortality

Infant mortality is a useful indicator of a country's level of health or development, and is a component of the physical quality of life index. In Canada, there was a substantial decrease in infant mortality and also declines in regional disparities in infant mortality, especially since the 1980s. Income-related differences in infant mortality diminished substantially; however, rates in the poorest neighbourhoods in the country have remained higher than those in the most well-off neighbourhoods. (Statistics Canada, "Infant mortality and low birthweight, 1975 to 1995," *Health Reports*, Winter 1997.)

Families with poor birth outcomes are disproportionally represented among young mothers, single mothers, mothers with low socioeconomic status, mothers with low educational attainment and mothers who did not receive adequate prenatal care. These mothers tend to experience barriers to a healthy pregnancy such as accessing adequate nutrition, housing, health care services and social supports.

Infant mortality rate (per 1000 live births)

	1998	1999	2000	2001	2002	2003	2004
Canada	5.3	5.3	5.3	5.2	5.4	5.3	5.3
Saskatchewan	7.1	6.3	6.8	5.5	5.7	6.3*	6.2*

Source: Canadian Vital Statistics — Mortality Database, Summary List of Causes, Statistics Canada. *Data reported in 2004/2005 based on crude rate from *Annual Rate on Saskatchewan Vital Statistics, 2004*.

Early Development

Motor and social development

After nine months of pregnancy, a baby is born with a brain that will experience significant development and growth in the coming months and years. Basic functions like sucking, swallowing and breathing are hard wired in the infant's brain, but the regions that control the rest of the body are still forming and connecting.

Gross motor development begins in a "top down" fashion, starting with control over the head and neck as nerves mature and neck muscles gain strength. Next come the shoulders and upper arms. This is followed with control over the torso, then the hips and pelvis, and finally the legs.

Infant social development begins with interactions with primary caregivers, especially parents. The quality of exchanges between infant and parent creates a foundation for the infant's social and cognitive development.

Secure attachments are formed when parents are able to meet the needs of their infants by feeding them when they are hungry, changing their diapers when needed, holding and cuddling them, or smiling and

talking to them. These actions are the basis for healthy relationships with other people.

Infants who receive few or predominately negative interactions with caregivers will initially attempt to induce positive facial expressions before going into a state of withdrawal. Eventually, the infant will begin to associate interactions with the caregiver as negative or stressful. As adults, these children may be at greater risk of experiencing depression, anxiety, post traumatic stress, aggression, impulsiveness, delinquency, hyperactivity or substance abuse. (McCain et al. *Early Years Study 2: Putting Science into Action*, Council for Early Child Development, March 2007.)

Motor and social development, children 0 to 3 years

	Advanced (%)		Average (%)		Delayed (%)	
	SK	Can	SK	Can	SK	Can
1998-1999	19.3	15.0	69.1	71.9	11.6	13.9
2000-2001	13.2*	13.3*	73.3*	74.8*	13.4*	11.8*
2002-2003	10.7	13.2	74.1	73.2	15.2	13.6
2004-2005	10.3	10.5	74.0	73.1	15.7	16.4

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4 -v2 (2000-2001), and Cycle 5 (2002-2003), Cycle 6 (2004-2005) Child Questionnaire. Exclusions: Children aged 4-5 years; children living in the Territories; children living on reserve; children living in institutions. *Data differs from previous reports.

Emotional Health

- **Emotional problem / anxiety**
- **Hyperactivity / inattention**
- **Physical aggression / conduct problem**
- **Prosocial behaviour**

Emotional health is one of the areas examined in the National Longitudinal Survey of Children and Youth (NLSCY). The survey uses behaviour scales to assess the extent of certain aspects of a child's behaviour. These include emotional problems and anxiety, hyperactivity and inattention; physical aggression and conduct problems; and social behaviour.

It is normal for young children's emotions to change frequently and without apparent cause. Sometimes children cling to their parents and then swing unexpectedly to defiance or independence. It is also during the early years that children begin to develop an identity and an understanding of who they are in relation to the rest of the world.

Between the ages of two and five years, children begin learning social skills such as self-control, sharing and cooperating with others. Primary caregivers can support children to develop empathy to recognize and understand other's feelings. Addressing emotional, behavioural and anxiety problems is important in the early years in order to prevent future challenges and the development of more serious

psychiatric illness in adolescence and adulthood.

The foundational building block to emotional health in a child is healthy attachment to a primary caregiver. The ability to trust and form reciprocal relationships affects the emotional health, security, and safety of the child, as well as the child's development and future interpersonal relationships. The ability to regulate emotions, develop a sense of right and wrong, and experience empathy are founded in secure attachment relationships.

Emotional health, children ages 2 to 5 years

	Low Prosocial (%)		High Aggression (%)		High Hyperactivity (%)		High Emotional Problems (%)	
	SK	Can	SK	Can	SK	Can	SK	Can
1998-1999	11.8	10.2	15.5	13.5	14.6	12.2	12.1	13.8
2000-2001	16.7*	16.0*	16.6*	12.6*	14.8*	15.1*	17.9*	17.8*
2002-2003	14.1	15.7	16.8	14.6	5.6 *	5.5	15.4	16.7
2004-2005	11.5	14.6	17.9	14.2	**	6.6	12.7	14.7

Emotional health is defined as the proportion of children aged 2-5 years who exhibit high levels of emotional and/or anxiety problems. Emotional problems/anxiety is one of a number of behaviour scales examined in NLSCY. The purpose of the behaviour scales are to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the person most knowledgeable (PMK) of the child and do not represent professionally diagnosed problem behaviours. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), and Cycle 5 (2002-2003), Cycle 6 (2004-2005) Child Questionnaire. Exclusions: Children aged 0 to 1 year; children living in the Territories; children living on reserve; children living in institutions. *Data differs from previous reports. ** Unacceptable data quality, data has been suppressed.

Language skills

Scores on the Peabody Picture Vocabulary Test (revised) (PPVT-R) can be a predictor of later school success. The test is designed to measure receptive or heard vocabulary in either English or French. The test is administered by the interviewer directly to children aged four and five years. It can also provide one dimension of school readiness by measuring verbal ability. There are strong linkages between PPVT-R scores and parenting style and parental education levels. However, socioeconomic status is not closely linked to PPVT-R scores.

Language development explodes during the early years. This time period is the most sensitive to language development and is connected to later competency. It begins with infants who can respond to their name and communicate through crying or gurgling, and progresses to preschoolers who can communicate complex concepts.

Longitudinal evidence shows verbal delays during the first three years of life are linked to poor language and literacy for school-aged children. (McCain et al, *Early Years Study 2: Putting Science into Action*, Council for Early Child Development, March 2007.)

Language skills: Peabody Picture Vocabulary Test — Revised (PPVT-R)						
	Advanced (%)		Average (%)		Delayed (%)	
	SK	Can	SK	Can	SK	Can
1998-1999	10.2	13.3	78.8	70.8	15.9	15.9
2000-2001	15.1*	16.4*	76.3*	69.1*	8.6*	14.5*
2002-2003	14.4	17.3	72.4	69.6	13.2	13.1
2004-2005	—	16.5	—	70.0	—	13.6

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Child Questionnaire. Exclusions: Children aged 0-3 years; children aged 4-5 years for whom the person most knowledgeable (PMK) did not provide consent for the PPVT-R to be administered; children living in the Territories; children living on reserve; children living in institutions. *Data differs from previous reports.

Safety and Security

Injury hospitalization

Injury hospitalization and injury mortality rates are public health measures of reported cases of hospitalization or death due to injury. Greater public awareness of the causes of child injury and changes in attitudes towards the use of seat belts and car seats in automobiles; helmets while using bicycles, scooters, motorcycles and snowmobiles; and lifejackets for watercraft have dramatically reduced injury and death.

Considerable variation in injury rates across Canada reflects differences such as lifestyle and agricultural production regionally and ease of access to emergency services in remote areas. Injury rates are also strongly linked to income levels, family composition and household size. These factors may contribute to Saskatchewan's relatively high rate of childhood injury among all the provinces.

Also, different jurisdictions and statistical collection agencies classify data differently, resulting in differences in figures.

Fortunately, relatively few young children die or receive major injuries in Saskatchewan and Canada. Due to the small number of cases of injury requiring hospitalization or resulting in death, even a single case can greatly affect the rate per 100,000 cases. The following two charts must be read with caution, as the small number of cases in Saskatchewan is a major limitation of this indicator.

Injury hospitalization for population less than 1 year of age — number of cases and rate per 100,000

CANADA	1999-2000		2000-2001		2001-2002		2002-2003		2003-2004		2004-2005	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	1,624	479.5	1,465	436.8	1,495	447.5	1,472	448.6	1,388	417.8	1,327	394.5
Falls	702	207.3	658	196.2	658	197.0	643	195.9	594	178.8	579	172.1
Suffocation	146	43.1	110	32.8	105	31.4	95	28.9	72	21.7	65	19.3
Poisoning	98*	28.9	68	20.3	90	26.9	106	32.3	110	33.1	99	29.4
Contact with hot object	81	23.9	91	27.1	77	23.0	90	27.4	78	23.5	61	18.1
Struck by / against an object, person or animal	53	15.6	49	14.6	49	14.7	38	11.6	39	11.7	32	9.5
Natural environment	21	6.2	28	8.3	22	6.6	26	7.9	27	8.1	12	3.6
Assault	179	52.8	157	46.8	201	60.2	179	54.5	154	46.4	147	43.7

SASKATCHEWAN	1999-2000		2000-2001		2001-2002		2002-2003		2003-2004		2004-2005	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	94	751.3	74	606.9	80	672.0	102	858.8	86	726.8	64	534.0
Falls	38	303.7	21	172.2	28	235.2	32	269.4	20	169.0	23	191.9
Suffocation	10	79.9	10	82.0	6	50.4	*	*	*	33.8	*	*
Poisoning	8	63.9	6	49.2	7	58.8	10	84.2	14	118.3	*	*
Contact with hot object	*	*	*	*	*	*	*	*	8	67.6	*	*
Struck by / against an object, person or animal	*	*	*	*	*	*	*	*	*	8.5	*	*
Natural environment	*	*	*	*	*	*	*	*	*	25.4	*	*
Assault	12	95.9	13	106.6	16	134.4	20	168.4	16	135.2	12	100.1

Canada information does not include data for Nunavut 2002-03. Nunavut did not report injury hospitalization data for that year. Exclusions: newborns, out-patient and emergency department visits. The injury hospitalization rate = number of hospitalizations for treatment of injuries per total population aged less than one year x 100,000. All assaults are the result of external causes of injury. Source: Canadian Institute for Health Information (CIHI) Hospital Morbidity Database: province/territory of hospitalization used; figures based on the number of patients (0 to 1 year) who were admitted to an acute-care facility (minimum overnight stay) in Canada and subsequently discharged (alive or dead) from that facility. Causes of injury are based on the first reported external cause of injury code. The year represents the fiscal year of hospital separation (including discharges and deaths); and population denominators are less than 1 year of age, and between 1 and 4 years of age, respectively, by fiscal year midpoint (October 1) and are specific to gender, province and fiscal year. *Indicates suppressed value - all values less than 6, including zeros, were suppressed before 2003-04; and values less than 5, including zeros, were suppressed in 2003-04 and forward, in accordance with the Public Health Agency of Canada's agreement with CIHI.

Injury hospitalization for population 1 year of age to less than 5 years — number of cases and rate per 100,000

CANADA	1999-2000		2000-2001		2001-2002		2002-2003		2003-2004		2004-2005	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	6,840	461.8	6,396	442.3	5,708	401.4	5,503	393.6	5,222	378.8	5,099	372.6
Falls	2,634	177.8	2,423	167.5	2,293	161.2	2,152	153.9	2,121	153.9	2,027	148.1
Suffocation	202	13.6	187	12.9	176	12.4	142	10.2	124	9.0	88	6.4
Poisoning	1,108	74.8	1,109	76.7	932	65.5	885	63.3	797	57.8	769	56.2
Contact with hot object	346	23.4	304	21.0	249	17.5	320	22.9	270	19.6	278	20.3
Struck by / against an object, person or animal	284	19.2	299	20.7	257	18.1	280	20.0	258	18.7	285	20.8
Natural environment	336	22.7	361	25.0	275	19.3	241	17.2	248	18.0	257	18.8
Assault	140	9.5	126	8.7	111	7.8	98	7.0	89	6.5	82	6.0

SASKATCHEWAN	1999-2000		2000-2001		2001-2002		2002-2003		2003-2004		2004-2005	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	480	903.4	479	930.5	406	810.6	386	789.6	399	826.8	379	793.8
Falls	161	303.0	178	345.8	155	309.5	137	280.3	142	294.3	134	280.6
Suffocation	15	28.2	11	21.4	11	22.0	9	18.4	9	18.7	*	*
Poisoning	117	220.2	139	270.0	85	169.7	86	175.9	91	188.6	69	144.5
Contact with hot object	16	30.1	15	29.1	23	45.9	13	26.6	17	35.2	20	41.9
Struck by / against an object, person or animal	14	26.4	21	40.8	15	29.9	19	38.9	16	33.2	25	52.4
Natural environment	16	30.1	21	40.8	14	28.0	12	24.5	19	39.4	17	35.6
Assault	24	45.2	14	27.2	21	41.9	14	28.6	7	14.5	11	23.0

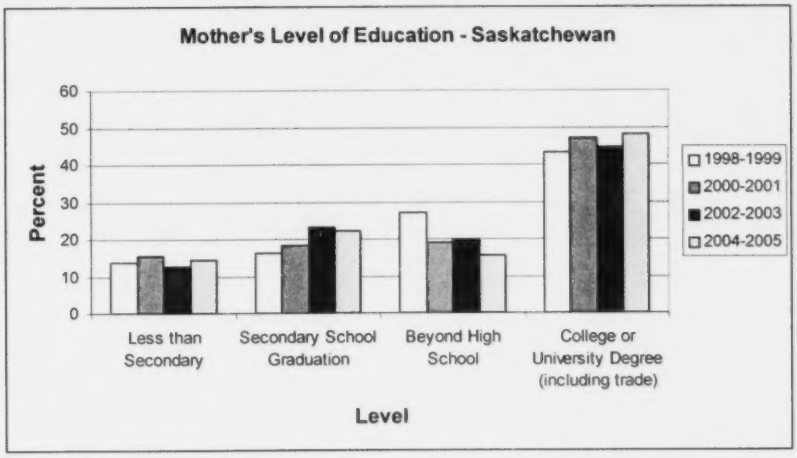
Canada information does not include data for Nunavut 2002-03. Nunavut did not report injury hospitalization data for that year. Exclusions: newborns, out-patients and emergency department visits. The injury hospitalization rate = number of hospitalizations for treatment of injuries per total population aged 1 year and less than 5 years x 100,000. All assaults are the result of external causes of injury. Source: Canadian Institute for Health Information (CIHI) Hospital Morbidity Database: province territory of hospitalization used; figures based on the number of patients (aged 1 year and less than 5 years) who were admitted to an acute-care facility (minimum overnight stay) in Canada and subsequently discharged (alive or dead) from that facility. Causes of injury are based on the first reported external cause of injury code. The year represents the fiscal year of hospital separation (including discharges and deaths). Population denominators are aged 1 year and less than 5 years of age, respectively, by fiscal year midpoint (October 1) and are specific to gender, province and fiscal year. * Indicates suppressed value - all values less than 6, including zeros, were suppressed before 2003-04; and values less than 5, including zeros, were suppressed in 2003-04 and following, in accordance with the Public Health Agency of Canada's agreement with CIHI.

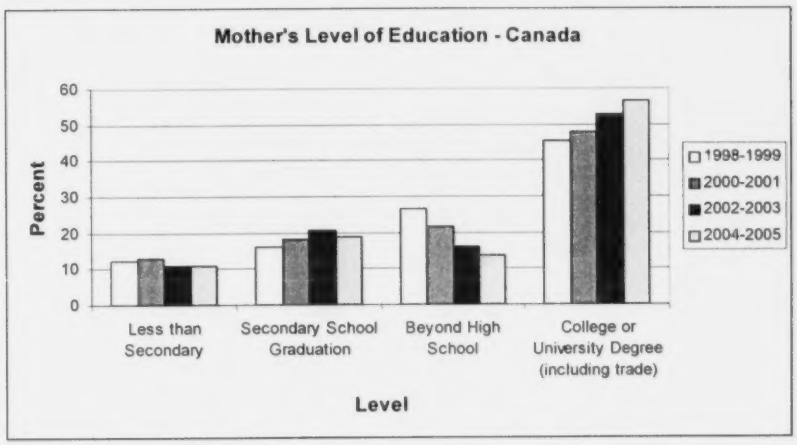
Parental education

Literacy and education levels are key social determinants of health. The inability to follow directions on medication, follow-up with medical advice and appropriately mix baby formula are some short-term implications of low literacy levels. In the longer term, education impacts employment opportunities, employment stability and earned income. These in turn impact housing quality, food security and early learning and child care options for families.

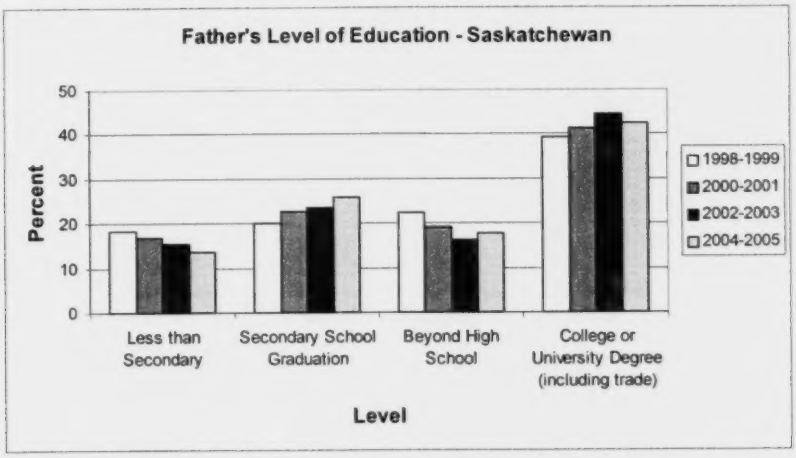
There are intergenerational impacts of parental education. Children who grow up in families with lower socioeconomic status tend to do less well in school, are less likely to attend postsecondary education and have greater difficulty entering the labour market than their more advantaged counterparts.

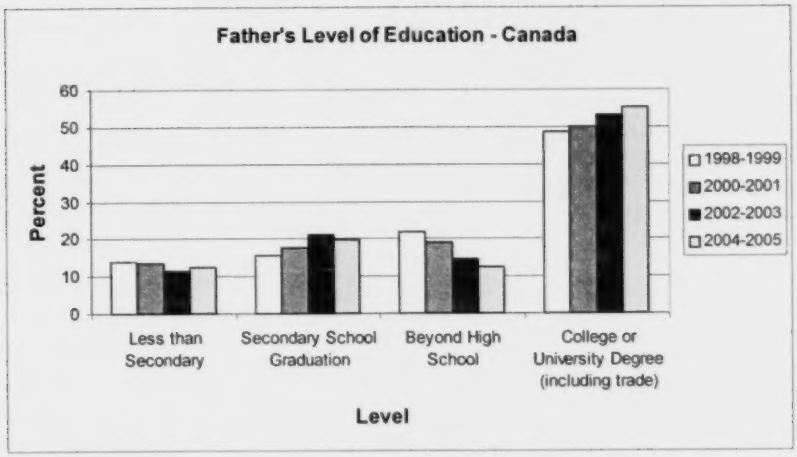
Though socioeconomic status is strongly linked to childhood outcomes, this is not an absolute rule. Children from poorer backgrounds can exhibit significant resilience and children from affluent families can experience behaviour and academic difficulties.





Definition: The highest level of education attained by the mother of children aged 0 to 5 years. This indicator refers to biological, step, adoptive or foster mother who is living with the child. Note that this indicator will not represent the education status of mothers of children living in male-headed single-parent households.
Exclusions: Children whose person most knowledgeable (PMK) (or spouse of the PMK) is not a biological, step, adoptive or foster mother; children living in the Territories; children living on reserve; children living in institutions.
Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001) and Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.





Definition: The highest level of education attained by the father of children aged 0 to 5 years. This indicator refers to biological, step, adoptive or foster father who is living with the child. Note that this indicator will not represent the education status of fathers of children living in female-headed single-parent households. Exclusions: Children whose person most knowledgeable (PMK) (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2(2000-2001) and Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

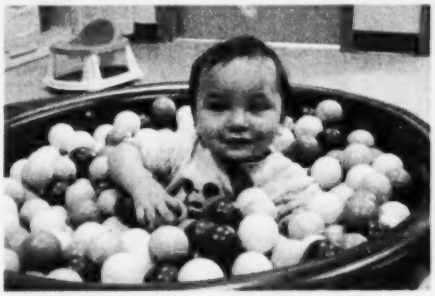
Income level

Low Income Cut-Off rates (LICOs) are income thresholds determined by analyzing family expenditure data obtained through the Survey of Labour Market and Income Dynamics, Statistics Canada, which samples information from a large survey of Canadian families. The LICO is the threshold below which families will likely devote a larger share of their income to the basic necessities of food, shelter and clothing than would the average family. LICOs are not poverty lines. Because LICOs are relative measures of all income levels, considerable variation can occur from year to year. Beginning with the *Early Childhood Development Progress Report 2004/2005*, Saskatchewan has chosen to show trends in the percentage of families with young children living below the LICO using a three year moving average in addition to yearly data provided by Statistics Canada. This evens out yearly fluctuations while making trends over time more evident.

Percentage of families with children under 6 years of age below after tax LICO (low income cut-off) (1992 base)

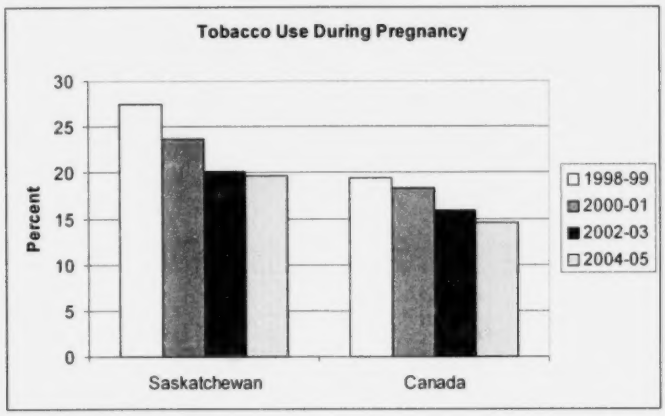
	Saskatchewan		Canada	
	Three-Year Average	**Below LICO**	**Three-Year Average**	**Below LICO**
1998	—	11.2	—	15.0
1999	13.3 *	13.3	15.4. *	15.5
2000	13.3 *	15.4	14.9 *	15.6
2001	11.8	11.1 *	14.3	13.5
2002	12.2	8.9 *	13.4	13.9
2003	12.4	16.6	13.2	12.7
2004	15.5	11.7	13.1	13.1
2005	—	18.3	—	13.4

Source: Survey of Labour and Income Dynamics (SLID) — Statistics Canada, Reference Years 1998, 1999, 2000, 2001, 2002, 2003, 2004 and 2005. Exclusions: Children living in the Territories. * Data differs from previous reports.



Tobacco use in pregnancy

According to the Canadian Lung Association, tobacco kills about 45,000 Canadians a year. The health risk is not exclusive to adults. Fetuses and young children are particularly susceptible to the harmful effects of tobacco smoke in their environment. Nicotine, carbon monoxide and other chemicals in tobacco smoke are passed on to the baby through the placenta. Babies of women who smoked or were exposed to second-hand tobacco smoke during pregnancy are, on average, smaller at birth than babies of non-smoking mothers. Children are also at greater risk of sudden infant death syndrome, reduced lung development and increased incidence and severity of respiratory illness. Reducing the number of women who smoke during pregnancy is an important public health objective. Smoking rates are highest among young women, low-income earners and those in remote communities. Cigarette and alcohol use often develop concurrently, and smoking is especially common among people treated for alcohol and other drug-use disorders. (Mark G. Myers and John F. Kelly, "Cigarette smoking among adolescents with alcohol and other drug use problems," *Alcohol Research and Health*, Fall 2006.)

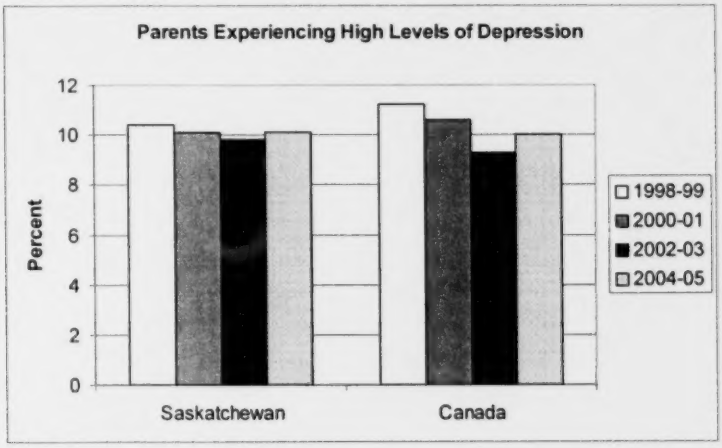


Definition: The proportion of children aged 0-1 years whose mother smoked during pregnancy with the child. Exclusions: Children aged 2-5 years; children living in the Territories; children living on reserve; children living in institutions. National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

Parental depression

Parental depression can have a substantial impact on an infant. Babies depend on emotional nurturance, protection and stimulation in order to develop optimally. Depressed mothers may not be able to consistently provide this stimulation. Children with highly depressed parents are more likely to exhibit challenging behaviour like anger and protective styles of coping, passivity, withdrawal, poor self-regulatory behaviour, reduced attention span and lower cognitive performance.

The following graph shows high levels of depression in the person most knowledgeable (PMK) about the child. A gender breakdown is not available. Factors that can place mothers at risk for depression include a prior history of depression, family history of depression, hormonal changes experienced during pregnancy, genetics, and environmental effects such as food insecurity, poor housing conditions, lack of financial supports and lack of social support networks.



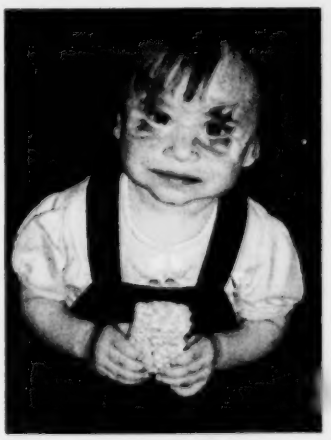
Definition: The proportion of children aged 0-5 years whose person most knowledgeable (PMK) exhibits high symptoms of depression. The Depression Scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression in the public at large and does not represent the occurrence of clinically diagnosed depression. The scale ranges in value from 0-36 with high scores indicating the presence of depressive symptoms. This scale is administered to the person most knowledgeable (PMK) about the child. Exclusions: Children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

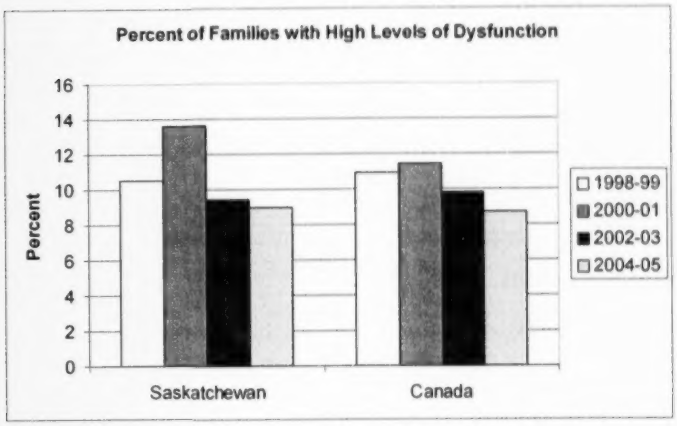
Family functioning

Family functioning refers to how well family members communicate with each other, work together and treat each other. It also relates to how well family members function as a unit and is tied to the quality of the relationship between parents and their children. Families who function well tend to have children who get along well with others and succeed in school.

The difference that families make to school success can be considerable. All families experience challenges in balancing work and family obligations, unexpected life events, child rearing difficulties, and ups and downs in relationships.

The National Longitudinal Survey of Children and Youth measures family functioning by asking parents a number of questions about problem-solving practises, expressive communication, decision making and levels of acceptance. Families with low scores exhibit a high degree of dysfunctional behaviour. This kind of family environment increases the likelihood of behaviour and emotional problems in children such as aggression and anxiety.





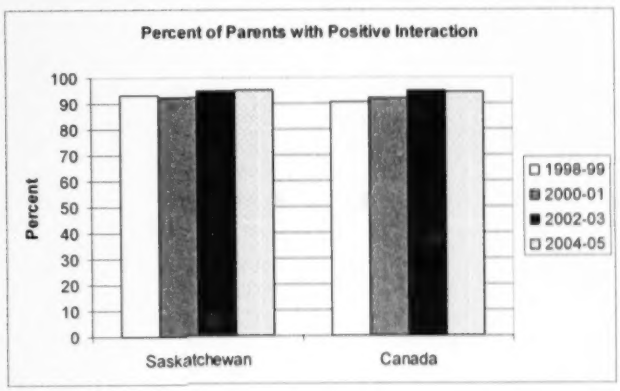
Definition: The proportion of children aged 0-5 years in families with high levels of dysfunction. The family functioning scale provides a global assessment of family functioning (including problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control) and indicates the quality of relationships among family members. This scale is administered to either the person most knowledgeable (PMK) about the child or the spouse/partner. The scale ranges in value from 0-36 with higher scores indicating family dysfunction. The scale does not reflect a clinical diagnosis. Exclusions: Children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

Positive Parenting

The parent-child relationship is the first relationship that children experience. It is the base from which children explore the world. The parent-child relationship is the basis for healthy social, emotional, intellectual and physical development of children. Parents support child development when they are warm and nurturing; listen for and respond sensitively to their child's needs; respond to their child's temperament and work with it; build on the strengths of their child; offer choices; and encourage problem solving and decision making.

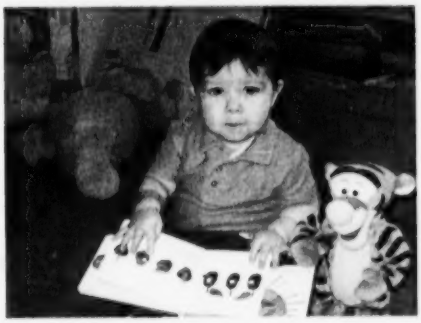
Positive parenting creates an attachment relationship that supports children to learn about and interact with the world around them.

In the National Longitudinal Study of Children and Youth, parents were asked how often they engaged in a number of positive parenting interactions with their children. These interactions included praise, playing together and laughing together.



Definition: The proportion of children aged 0-5 years whose parents did not exhibit low positive interaction with the child, as measured by the National Longitudinal Study on Children and Youth (NLSCY) parenting scales. The questions assessing parenting styles were administered to the person most knowledgeable (PMK) about the child or spouse/partner of the PMK. Exclusions: children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

Reading



Reading to children or listening to children reading out loud enhances the parent-child bond in a quiet, relaxed setting and contributes to emotional regulation and positive behaviour. It encourages literacy, familiarity with complex language and enhances vocabulary. Reading with children prepares them to learn to read by fostering their appreciation for books and familiarizing them with printed materials and story structures.

Literacy has a direct connection to family social and economic well-being. Canadians with low literacy are about twice as likely to be unemployed. (Statistics Canada, Human Resources and Skills Development Canada, US National Center for Education Statistics, Organisation for Economic Co-operation and Development, 2005, *International Adult Literacy and Skills Survey*, 2005.)

Children who are read to daily tend to have better receptive vocabularies and number knowledge when they begin school than children who are read to less frequently. (Eleanor M. Thomas, "Readiness to Learn at School Among Five-year-old Children in Canada", Children and Youth Research Paper Series, Statistics Canada, November 2006.)

Frequency adult reads to child and / or listens to child read — percentage of families

SASKATCHEWAN	1998-1999	2000-2001	2002-2003	2004-2005
A few times a week or less	29.8	11.2 *	9.1	7.1
Daily	59.3	22.0	24.1	22.7
Many times each day	10.9	66.8	66.8	70.2
CANADA	**1998-1999**	**2000-2001**	**2002-2003**	**2004-2005**
A few times a week or less	30.3	11.0	10.1	12.2
Daily	58.2	23.6	22.7	23.1
Many times each day	11.5	65.4	67.3	64.8

Definition: Distribution of children aged 0-5 years by how often an adult reads to the child or listens to the child read. This indicator refers to the exposure of the child to reading activities with a parent or another adult. Therefore, this indicator should not be interpreted to refer specifically to parent-child interactions. Exclusions: Children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), and Cycle 6 (2004-2005) Parent Questionnaire. * Marginal data quality — while this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

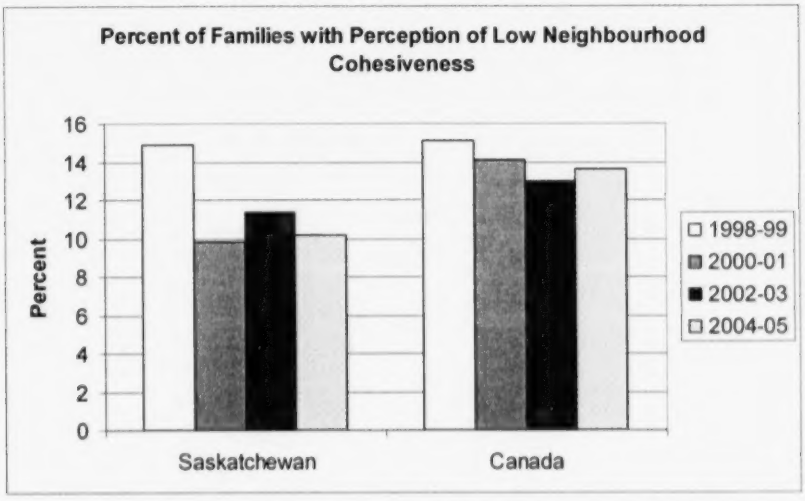
Neighbourhood cohesion

The neighbourhoods where children live and grow impact their health and well-being. Resources such as libraries, playgrounds, community centres, preschools, enrichment programs and early learning and child care can provide stimulating environments. The structural characteristics of a neighbourhood, such as average income, how often people move, or whether residents rent or own their homes either supports or detracts from social organization and cohesion. In neighbourhoods that have low levels of cohesion, children's emotional and behavioural development may be threatened by living in the midst of physical and social instability, as well as exposure to crime in the community.

Children's verbal ability scores tend to fall as the proportion of poor families and households led by a single mother increases, and as neighbourhood cohesion decreases. Children growing up in neighbourhoods with low levels of cohesiveness are less likely to be ready for school.

When neighbourhood cohesion increases, so does children's language ability. This may be due to the positive effects on parental emotional distress, social support, and health. (Clyde Hertzman and Dafna Kohen, "Neighbourhoods Matter for Child Development," *Transition Magazine*. Autumn 2003, vol. 33, no. 3.)

The neighbourhood cohesiveness score is based on perceptions of trust in neighbours, the presence of adults who are role models for children, cooperation between neighbours in dealing with problems, watching out for children's safety and the extent to which neighbours can be relied on to keep an eye on property.



Definition: The proportion of children aged 0-5 years living in neighbourhoods with low neighbourhood cohesion, as judged by the PMK (person most knowledgeable). The purpose of the neighbourhood scales is to assess the extent of the presence/absence of certain neighbourhood characteristics. In particular, the neighbourhood cohesion questions were administered to the PMK or spouse / partner of the PMK. Exclusions: Children living in the Territories; children living on reserve; children living in institutions. Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-1999), Cycle 4-v2 (2000-2001), Cycle 5 (2002-2003), Cycle 6 (2004-2005) Parent Questionnaire.

KidsFirst Performance Plan

Information about the decision-making and financial accountability structure of the intensive *KidsFirst* program in targeted communities, along with the performance results achieved by the program, is provided in this section.

Funding and policy direction for *KidsFirst* is provided by four provincial government ministries. The Ministry of Health funds the birth questionnaire, assessment and the home visiting program, as well as enhanced mental health and alcohol and drug addiction services. The Ministry of Education funds early learning programs, child care spaces and early intervention programs, as well as central program support and accountability. The Ministry of First Nations and Métis Relations and the Ministry of Social Services provide advice to the program.

Each *KidsFirst* site has a *KidsFirst* Management Committee that directs local implementation and planning. Typically these committees are made up of representatives from the health region, school division, Social Services regional office, First Nations and/or Métis organizations and community partners.

A partnership agreement exists between the accountable partner and the province. The provincial government sets policy and program direction, allocates funding, approves community plans, tracks and reports expenditures and evaluates progress of the program. The accountable partner, working collaboratively with the local *KidsFirst* Management Committee, is responsible for the continued development and implementation of the *KidsFirst* program at each site. *KidsFirst* communities report regularly on progress and expenditures for community initiatives.

Further information about the *KidsFirst* program can be obtained at www.education.gov.sk.ca/KidsFirst.

Performance Results

The *KidsFirst* program operates at capacity within existing resources. A set of performance measures has been developed in consultation with *KidsFirst* targeted communities and the partner ministries, in order to measure progress.

Family progress is reported in this document. 2006-07 is the first year that ongoing assessment information is available. Baseline data about families for 2006-07 is gathered from the in-depth assessment conducted at program admission. Questions from the in-depth assessment are re-posed to families that have been enrolled in *KidsFirst* through an ongoing assessment. This information shows the percentage of families that at the time of the ongoing assessment, scored below the threshold of risk established by the in-depth assessment and have since shown improvement. These families have been involved in *KidsFirst* for a minimum of six months and information was collected in 2006-07.

As families become more comfortable with *KidsFirst* staff, greater knowledge about family circumstances emerges. Ongoing data presented at this time provides a preliminary picture. Ongoing analysis of the data results, in consultation with *KidsFirst* staff, will be required to ensure that the circumstances experienced by *KidsFirst* families are accurately reflected.

Healthy Babies

Prenatal Care

For children to be born healthy, their mothers must also be healthy. Pregnant women who use alcohol and/or drugs during pregnancy require intensive supports to assist them to have a healthy pregnancy. Women are referred to *KidsFirst* services after they are pregnant. As a result, interventions focus on providing adequate nutrition and prenatal care in order to reduce the effects of drugs and alcohol on the fetus. *KidsFirst* home visitors also assist pregnant women in stabilizing their circumstances by helping them find safe housing and access to nutritious food. *KidsFirst* Mental Health and Addiction teams support expectant mothers to address mental health and addiction issues.

Key Actions for 2006-07

- Ensure pregnant women in the program have access to prenatal supplements.
    - 100% of pregnant women in the program had access to prenatal supplements.

- Ensure pregnant women and their families at all nine program sites had access to prenatal care and education programs.
    - 100% of pregnant women and their families at all nine program sites had access to prenatal care and education programs.

What are we measuring?	Where are we starting from? What is the change?
Percentage of pregnant women enrolled in the *KidsFirst* program that increase the number of prenatal **education** components they access.	63% *[2006-07 Baseline]* 80% *[2006-07 Families Improved]*
Percentage of pregnant women enrolled in the *KidsFirst* program that increase the number of prenatal **health care** components they access.	95% *[2006-07 Baseline]* Under development

The *KidsFirst* program focuses on three aspects of prenatal care – prenatal education, access to prenatal health care and providing prenatal vitamins and supplements. Since the growth and development of children begins during gestation, appropriate prenatal care impacts physical and cognitive outcomes for the child. If women do not receive adequate nutritional care while pregnant, they may be at risk for pregnancy complications and negative birth outcomes such as still births, low birth weight babies and infant death.

- In 2006-07, 80% of *KidsFirst* families who were not accessing prenatal education components at admission improved their access when they were later reassessed.

Mental Health and Addictions

A child's health and well-being is impacted when his or her family is challenged by mental health and addictions issues. It is particularly important to address alcohol and drug use by pregnant women because these substances have a direct negative impact on the developing fetus. It is also important to engage postnatal families regarding substance abuse and mental health issues. Postpartum depression is a common challenge among *KidsFirst* families, as it is among many new mothers. Postpartum depression can make it difficult for new mothers to bond with and form a secure attachment to their infant.

Key Actions for 2006-07

- Ensure pregnant women in the program have access to appropriate mental health and addiction services.
  - 100% of pregnant women in the program had access to mental health and addiction services.

- Ensure access to mental health and addiction services as required by families.
  - 100% of families had access to mental health and addiction services, as required.

KidsFirst provides dedicated mental health and addictions supports to families. While it is possible that families may access mental health, substance abuse and addictions supports without the assistance of *KidsFirst*, it is reasonable to assume that *KidsFirst* supports are important in linking families to services. Services are provided through creative outreach aimed at building strong relationships with families. This is particularly important to the First Nations and Métis families participating in *KidsFirst*, because experience within Saskatchewan regional health authorities shows that the First Nation and Métis population is underrepresented in voluntary mental health and addictions programs and overrepresented in similar programs ordered by the courts.

Child Health and Well-being

Studies examining child well-being and development demonstrate that children in lower socio-economic categories tend to be at greater risk of poor health status than children living in more favourable circumstances. Vulnerable families experience barriers to accessing preventative health services. Barriers include low incomes, lack of child care for other children and lack of transportation. As a result, families tend to wait until their health problems are serious before seeking medical help. This leads to complications such as increased infant hospitalizations, more severe illness and higher use of emergency health services. Inadequate prenatal care, out-of-date child immunization, lack of access to dental care, inadequate housing, family stress and poor nutrition also impact the health status of children.

KidsFirst communities work to remove barriers for families by providing transportation to immunization clinics and physician appointments, as well as providing child care services to enable parents to take their infants to medical check-ups. *KidsFirst* communities have also integrated primary health care education into their home visiting curriculum so that parents are aware of services available to them and the benefits to their child's health.

Key Actions for 2006-07

- Enable client families to access immunization for their children.
    - All nine communities provided client access to immunization. Five of the nine communities manually tracked child immunization; 79% of these families were up-to-date and appropriately immunized.

- Provide education regarding the benefits of consistent primary health care.
    - All nine communities provided families with education and information about the benefits of consistent primary health care, including obtaining a family doctor.

Even with the support of *KidsFirst*, there are a number of barriers to achieving this objective. Many *KidsFirst* communities experience high turnover of medical practitioners. This disrupts access to services and requires families to re-develop relationships with new professionals. In the North, many communities do not have easily accessible and consistent health care providers.

Social Determinants of Health

Encouraging the overall well-being and functioning of families within *KidsFirst* is key to their future success. The home visiting component of the program, along with community partnerships, allows linkages to programs and services outside of *KidsFirst* that support housing, food security, education, employment and income levels. Improvements in these areas are necessary to influence child development. While *KidsFirst* supports and advocates on behalf of families, a number of factors are beyond the direct scope of control of the *KidsFirst* program.

Key Actions for 2006-07

- Provide supports to families which promote development of social support networks.
    - All nine communities provided opportunities for families to develop and enlarge their social support networks through events such as annual family barbeques, Christmas parties, community gardens, swimming nights, bowling, community cooking classes, men's nights, and referrals to human service organizations.

- Assist families to access skills development, training and education resources, including literacy programs.
    - All nine communities provided access to and support in skills development, training, education and literacy programs.
    - 38% of families participated in programming aimed at developing skills, literacy and education in eight communities.

- Broaden family access to healthy and stable food resources.
    - In 2006-07, all nine communities participated in programs to support family food security, including food hampers, Good Food Box programs, community kitchens, cooking classes, nutrition information and community gardens.

- Facilitate families' access to available benefits programs.
    - All nine *KidsFirst* communities worked with the Ministry of Social Services, as well as other agencies, to ensure that families had access to available benefit programs.

Increased education, skills training and literacy improves a family's ability to become employed, raise their standard of living, and become independent of social assistance. Tracking improvements in education levels of *KidsFirst* participants provides a proxy for anticipated improvements in family income status and the ability to obtain safer and more adequate housing, transportation, nutritious food, early learning and child care, and recreation opportunities. *KidsFirst* itself has no direct influence on income levels, but works to provide the supports families need to build their skills and improve their circumstances over time. *KidsFirst* works with families to achieve this goal by providing access to education, skills training, literacy programs, transportation, child care, and support and mentoring from home visitors.

What are we measuring?	Where are we starting from? What is the change?
Percentage of *KidsFirst* families whose level of social support improves over time.	60% *[2006-07 Baseline]* 89% *[2006-07 Families Improved]*

Having someone to turn to for advice, moral support and practical assistance increases a family's ability to be a strong, nurturing unit. All families require assistance from supportive friends, relatives and community organizations. Opportunities that help *KidsFirst* families to build their own networks of support also help families to develop the skills and capacities necessary to make good choices, parent successfully and achieve their goals. Social isolation or weak social supports are linked to depression, as well as a sense of incompetence and frustration with being a parent.

KidsFirst works to remove barriers for families to participate in social events by providing transportation and child care, along with hosting events in *KidsFirst* families' home neighbourhoods.

- In 2006-07, 89% of *KidsFirst* families who did not have adequate social supports at admission, were found to have improved their social support network.

What are we measuring?	Where are we starting from? What is the change?
Families with adequate food security.	77% *[2006-07 Baseline]* 86% *[2006-07 Families Improved]*

Access to food is the foundation for the social determinants of health. Families with adequate food security have access to enough food for an active, healthy lifestyle. The food they eat is nutritionally adequate and safe. Families with food security are not reliant on emergency food supplies, scavenging, stealing or other coping strategies. Proper nourishment and nutrition supports healthy brain development in young children. There is a direct relationship between family income and family food security.

KidsFirst supports families to obtain and prepare nutritious foods, both directly and indirectly, by encouraging access to community kitchens, Good Food Box programs, instruction in food preparation, budgeting and ensuring appropriate enrolment in income support programs, along with access to food banks as necessary.

77% of *KidsFirst* families reported adequate food security when they were admitted to the program in 2006-07. However, an evaluation conducted by Regina *KidsFirst* showed that in 2006, 44% of families from *KidsFirst* Regina reported they did not have secure access to food. (Kahan, Barbara. *Outcome Evaluation 2002-2006, KidsFirst Regina Internal Working Document.* September 2006.) The Regina experience is consistent with anecdotal reporting. Given this discrepancy, further review and refinement of this indicator is necessary, along with developing a common definition of food security.

Family Interactions

Parents play a very important role in the development of their children. The quality of interactions between parents and children – if parents are warm and positive versus harsh and angry – is an important factor in child development. Children who are nurtured by emotionally healthy caregivers develop positive social and emotional behaviours. Many of the families in the *KidsFirst* program are struggling with these issues because of challenges coping with stress and crises and/or a lack of positive role models during their own childhood. Despite their desire to be good caregivers, many parents have not had the opportunity to learn positive parenting skills. This can lead to poor parent-child attachment, difficult child behaviours and negative emotional and social development of the child.

Key Actions for 2006-07

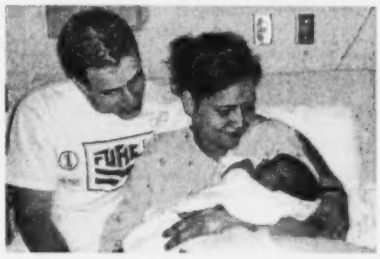
- Ensure access to existing community services targeted at development of stronger parenting skills.
    - All nine communities provided access to supports to help families develop stronger parenting skills.
    - In 2006-07, six of the nine communities tracked participation in activities to improve parenting skills. 32% of families participated in opportunities offered.

- Refer families who identify violence as an issue to appropriate service providers.
    - 100% of families who identify violence as an issue in their home were referred to appropriate professionals and service providers.

- Ensure the program is compliant with *The Provincial Child Abuse Protocol.*
    - All nine communities were compliant with *The Provincial Child Abuse Protocol.*

What are we measuring?	Where are we starting from?
Percentage of *KidsFirst* families with realistic expectations of age-appropriate behaviour when exhibited by the child.	70% *[2006-07 Baseline]* 86% *[2006-07 Families Improved]*
Percentage of *KidsFirst* families that exhibit and express positive acceptance of the child.	70% *[2006-07 Baseline]* 79% *[2006-07 Families Improved]*
Percentage of *KidsFirst* families that have no impediments in order to be motivated and responsible for meeting the needs of the child.	78% *[2006-07 Baseline]* 88% *[2006-07 Families Improved]*
Percentage of *KidsFirst* families in which the adult caregivers provide appropriate amounts of emotional nurturance and support to the child and family members.	63% *[2006-07 Baseline]* 83% *[2006-07 Families Improved]*

Supportive parent-child relationships begin during infancy with the attachment process. *KidsFirst* home visitors guide parents to create strong attachments with infants — by holding, cuddling, playing with and being responsive to the infant's cues. In this way, infants form secure attachments to their parents. This is the foundation for future social relationships. *KidsFirst* home visitors at all sites provide parents with suggestions based on a standardized curriculum that was developed based on research and best practises in early childhood development.



As children grow from infants into toddlers, parents continue to provide emotional nurturance and support. Home visitors work with parents to develop reasonable expectations about the age appropriate abilities of their children. Parents are also encouraged to establish clear and consistent boundaries with their children.

- In 2006-07, 86% of *KidsFirst* parents who did not have age appropriate expectations of their children at program admission, improved expectations.
- In 2006-07, 79% of *KidsFirst* families who had scored below the cut-off at admission, later showed improvements in the acceptance of and engagement with their children.
- In 2006-07, 88% of *KidsFirst* parents involved in the program who had scored below the cut-off at admission improved their ability to meet their children's needs and reduced the impediments they experienced to caring for their children.
- In 2006-07, 83% of *KidsFirst* families who scored below the cut-off at admission showed improved nurturance when they were re-assessed.

The existence of violence in the home is a serious societal concern that touches many families, including families enrolled in *KidsFirst*. *KidsFirst* communities work to raise awareness, respond to and prevent violence so that children can live in safe and stable home environments. Program staff work with parents to identify violence. Building strengths, self-esteem and confidence are important first steps in eliminating violence in homes.

Safe and Secure Home Environment

Children thrive in environments that are safe and free from physical hazards, filled with positive stimuli, and have adequate space for play and learning. *KidsFirst* supports families to find safe, secure housing and provides families with information about ways to increase home safety.

Key Actions for 2006-07

- Provide education related to housing and home safety.
  - All *KidsFirst* communities provided education related to housing and home safety.

What are we measuring?	Where are we starting from? What is the change?
Percentage of *KidsFirst* families who have taken action to improve the safety of the living conditions of their home.	85% *[2006-07 Baseline]* 94% *[2006-07 Families Improved]*
Percentage of *KidsFirst* families who have taken action to ensure they are living in suitable housing.	84% *[2006-07 Baseline]* 83% *[2006-07 Families Improved]*
Percentage of *KidsFirst* families living in stable housing for the foreseeable future.	67% *[2006-07 Baseline]* 88% *[2006-07 Families Improved]*

Engaging families in activities that help address home safety and security issues is important in improving their housing conditions. Suitable, stable and adequate housing supports the social, emotional, spiritual, cognitive and physical development of children and families.

KidsFirst communities work to ensure families are aware of preventable health and safety risks to their children. Home visitors provide guidance for change in areas such as:

- fire safety and working smoke detectors in the home;
- child-proofing play areas and other living spaces;
- safe cribs;
- safe, properly installed car seats;
- instruction on basic first aid; and
- ways to prevent children choking on or swallowing small items.

In 2006-07:

- 94% of existing *KidsFirst* families who had unsafe conditions in their homes at admission, had taken steps to make their homes as safe as possible by removing hazards and making changes when unsafe conditions were pointed out.
- 83% of existing *KidsFirst* families living in housing in need of major repairs were able to improve the suitability of their housing.
- 88% of families who had a high degree of housing instability at admission, reported at reassessment that their housing situation was more stable.

KidsFirst also asks families about their housing suitability. In this case, dwellings are considered suitable when there are enough bedrooms for the size and make up of the family in the household according to National Occupancy Standard requirements. These requirements are based on the number of people living in the residence compared to the number of bedrooms.

- In 2006-07, 51% of *KidsFirst* families did not have suitable housing when they were admitted into the program.
- In 2006-07, 10% of families who did not have housing to match their family size and composition at admission, were later able to improve their housing adequacy.

Learning Development

Ability to Learn

KidsFirst communities work with partner agencies to provide stimulating environments, play-based learning, and early identification and support for children with special needs to promote their ability to learn. For some families, structured care and learning environments outside the home complement their efforts to address social and economic challenges. High quality early learning and child care settings promote later success in school achievement.

Key Actions for 2006-07

- Track early learning activities and child progress.
    - The progress of children and families was tracked through the *KidsFirst* Information Management System (KIMS). Information includes records from 2001 to present. Development to this point allows for baseline and ongoing assessment data to be drawn from the system. This information is profiled in this report. Further development of this system will allow for further information about *KidsFirst* families as they progress through the *KidsFirst* program.

What are we measuring?	Where are we starting from?
Comparative rate of child development using the Ages and Stages Questionnaire (ASQ).	94% *[2005-06 Baseline]* 94% *[2006-07]*
Comparative rate of child development using the Ages and Stages Questionnaire: Social/Emotional (ASQ-SE).	82% *[2005-06 Baseline]* 82% *[2006-07]*

Child development is optimized within specific time frames or windows of opportunity. Though children have natural resilience and an ability to "catch up", when windows of opportunity are not optimized, children do not develop at typical rates. Addressing these gaps later in life often requires more intensive and costly interventions.

- In 2005-06 and 2006-07, 94% of children in *KidsFirst* were developing at normally expected rates in areas of communication, gross and fine motor skills, problem-solving abilities and personal-social skills.

- In 2005-06 and 2006-07, 82% of *KidsFirst* children had normal emotional development.

The tools used to assess development, the Ages and Stages Questionnaires, are used extensively in North America and considered reliable. Children scoring outside of the normative range on the Ages and Stages Questionnaire are referred to early childhood human service professionals.

Communication and problem solving are two areas where many *KidsFirst* children face challenges in development and score outside of the normative ranges established by the Ages and Stages Questionnaire and the Ages and Stages Questionnaire: Social/Emotional. This has implications for service providers within *KidsFirst* and its partners, especially the education system. Further analysis of this result is required, and an enhanced focus on communication and problem-solving skills may be indicated.

What are we measuring?	**Where are we starting from?**
Percentage of *KidsFirst* families participating in Growing Great Kids curriculum.	64% *[2005-06 Baseline]* 68% *[2006-07]*

The *KidsFirst* program encourages families to enhance their parenting skills in a variety of ways. The Growing Great Kids curriculum, delivered by home visitors, encourages parents to interact with their children to support brain development and cognition, nurture the parent-child bond and recognize children's needs by identifying cues. All home visitors in the *KidsFirst* program are trained in the Growing Great Kids curriculum. Home visitors guide parents through the curriculum and work together to create a developmentally stimulating and loving environment in the home.

- In 2006-07, 68% of *KidsFirst* families were actively participating in the Growing Great Kids curriculum.

The *KidsFirst* program is actively working to increase the percentage of families actively participating in the Growing Great Kids curriculum. Research shows that a high quality curriculum, delivered consistently, is important to positive outcomes for children and families.

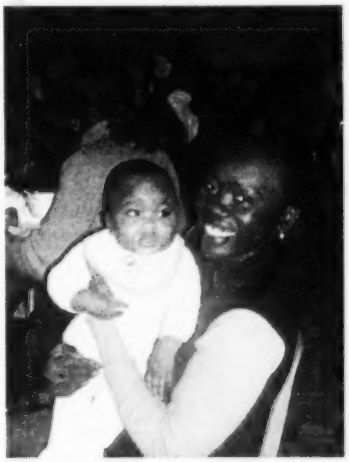
KidsFirst home visitors are trained to incorporate positive modelling to parents in all regular home visits, regardless of the age of the child. Also, community events often involve activities that support parent-child interactions, encourage the use of strength-based problem-solving skills and support ways to enhance child development. Parents are supported by *KidsFirst* partnerships with agencies, such as the Early Childhood Intervention Program, which provide specialized supports to *KidsFirst* children with developmental challenges.

Accountability

Community partnerships are at the core of the development and implementation of the *KidsFirst* program. Leadership of the *KidsFirst* program is shared by the province and the communities receiving *KidsFirst* funding.

Key Actions for 2006-07

- Ensure long-term program sustainability of community *KidsFirst* annual plans.
    - All communities provided annual budget plans in 2006-07 that were reviewed for long-term sustainability.



- Ensure program participation is compliant with *The Freedom of Information and Protection of Privacy Act* and *The Health Information Protection Act*.
    - All nine communities were compliant with *The Freedom of Information and Protection of Privacy Act* and *The Health Information Protection Act*.

- Implement Phase II of the *KidsFirst* Information Management System (KIMS) to measure performance of the program in relation to family progress.
    - The first phase of the *KidsFirst* Information Management System (KIMS) was implemented in 2005-06. Implementation of the second phase was completed in 2006-07.

- Prepare and publish reports to the public on investments and progress in accordance with provincial and federal requirements.
    - In 2006-07, reports were published by the province to detail public investments in early childhood development. These included the *Early Childhood Development Progress Report 2005/2006*, to meet federal and provincial requirements and the *2006-2007 KidsFirst Strategy* to meet provincial reporting requirements.

Service System for Early Childhood Development and Community Development

Program staff work with community partners to build human service systems that are integrated, seamless and responsive to family circumstances.

Key Actions for 2006-07

- Ensure maintenance of appropriate representation on the local management committees, with particular emphasis on Aboriginal representation.
    - All communities had management structures that represented the diverse interests of their communities. In 2006-07, all communities report Aboriginal representation.

- Continue building partnerships at the community level to effectively provide supports to *KidsFirst* families.
    - All communities engaged in partnerships at a local level. These partnerships included agencies such as the Early Childhood Intervention Program (ECIP), Canadian Prenatal Nutrition Program (CPNP), food banks, Tribal Councils, Aboriginal Head Start, First Nations and Métis service agencies, Royal Canadian Mounted Police (RCMP), Regional Intersectoral Committees (RICs), Community Action Program for Children (CAPC), municipal governments, school divisions, health regions, fire departments, transition houses, early learning and child care centres, health providers and others. Additionally, *KidsFirst* communities provided joint training sessions for partner agencies and *KidsFirst* staff, and participated in training sessions offered by other community agencies.

- Continue work at the interministry level for integration of complementary programs that support children and families.
    - Staff in the Early Learning and Child Care Branch of the Ministry of Education contributed to the Cognitive Disabilities Strategy, the Early Learning and Child Care Strategy, the Federal/Provincial/Territorial Working Group on Early Childhood Development, the Federal/Provincial/Territorial Knowledge Committee, the Understanding the Early Years Projects, Early Learning Program Guide, Income Supports and many other program and policy development committees.

The *KidsFirst* program has focused on achieving sustainability by building on existing resources, organizations and structures. This has allowed *KidsFirst* to direct most resources towards programming for families. It has also allowed *KidsFirst* to benefit from the experience and expertise of communities and build on pre-existing early childhood development networks, and increase the capacity of existing community-based organizations.

KidsFirst works to address the range of social determinants of health in families. This comprehensive approach works with broad systems like income security, health, education, food security, housing and transportation. The experiences of *KidsFirst* families, and by proxy all vulnerable families in the province, have provided valuable information for partners to come together and collectively solve problems in new ways.

Family Participation

Because the *KidsFirst* program is targeted to families in very vulnerable circumstances, it is important that there are processes in place to engage families. Families may move frequently within and between *KidsFirst* and other communities, as well as First Nations. They also experience barriers to accessing mainstream services and may be wary of involvement in government services.

Key Actions for 2006-07

- Strive towards the universality of screening babies at birth that are born in Saskatchewan.
    - All nine *KidsFirst* communities work in partnership with their regional health authorities to ensure all families with new infants have the opportunity to respond to the birth questionnaire. The focus of this work in 2006-07 was in targeted *KidsFirst* communities, where over 80% of Saskatchewan babies were born. Regional *KidsFirst* Community Developers developed strategies to increase the rate of birth questionnaire coverage in smaller hospitals in the province.

- Provide appropriate training for screening personnel within targeted community hospitals.
    - A training video was developed and distributed in 2006-07 as a provincial resource to support consistent administration of the birth questionnaire. It also provided information to health care providers regarding the impact of completion of the birth questionnaire on future policy development.

What are we measuring?	Where are we starting from?
The rate of in-hospital birth questionnaires per hospital live births in Saskatchewan.	64% *[2005-06]* 69% *[2006-07]*

The in-hospital birth questionnaire asks questions about a family's health and socio-economic circumstances when a child is born. When aggregated, this information can provide a broad snapshot of the demographics of families with infants. The questions also equip service providers with information to link families to the spectrum of available early childhood development services, which includes *KidsFirst*, when they return home from the hospital. Success in achieving a high rate of birth questionnaire completion is dependent upon strong relationships with the province's regional health authorities and staff in hospitals who conduct the questionnaires. Based on Saskatchewan Health data, from July 1, 2006 to June 30, 2007, 69% of families who had babies in the province participated in the questionnaire. In 2005-06, 64% of new parents participated.

In 2006-07, 10,246 of a total of 12,140 births in Saskatchewan took place in hospitals in Meadow Lake, Moose Jaw, the North, North Battleford, Regina, Saskatoon, Prince Albert and Yorkton. According to *KidsFirst* data collected from March 31, 2006 to April 1, 2007, 84% of new parents who had babies in these nine communities (8,292 of a total 9,883 families) participated in the birth questionnaire.

Among those families who responded to the questionnaire, approximately 33% (3,217) had circumstances that made their child vulnerable to develop below expected levels due to health challenges or family circumstances. 10% of the families (854 families) scoring in this range lived in targeted *KidsFirst* neighbourhoods.

The remaining 24% of families (2,363 families) lived in urban, rural and First Nations communities outside of the targeted areas. These families have access to the early childhood development resources available to the broader community, including Early Childhood Intervention Program, early learning and child care, public health nurses, parenting groups, Prekindergarten programs, First Nations and Métis services, Mom and Tots groups, community kitchens, preschool and nursery school programs, speech language, occupational and physical therapists, and parent mentoring programs.

Families Satisfaction with *KidsFirst*

Measuring satisfaction with the services provided is important to ensuring that programs are relevant and meaningful for participants. Several *KidsFirst* communities have undertaken client satisfaction surveys in order to implement improvements on a local basis. Some of the communities have also evaluated various aspects of the program. A provincial parent satisfaction survey was developed in consultation with the *KidsFirst* sites.
In 2005-06, four communities completed provincial parent satisfaction surveys. The provincial component of parent satisfaction will be implemented in collaboration with all targeted communities in future years.

Key Actions for 2006-07

- Implement a parent satisfaction survey for all *KidsFirst* targeted communities.
    - Six of the nine communities implemented a provincial parent satisfaction survey in 2006-07. In 2007-08, all communities will implement the provincial survey.

What are we measuring?	Where are we starting from?
The level of parental satisfaction with *KidsFirst* program services through their home visitor.	94% *[2005-06 Baseline]* 98% *[2006-07]*

There is a balance between effectiveness and popularity. The degree of satisfaction participants have with the program may be influenced by their life experiences. The perception families have about a service can also be the result of their expectations when they began participating in the service.

- In 2006-07, Meadow Lake, Moose Jaw, North Battleford, Prince Albert, Saskatoon and Yorkton *KidsFirst* sites participated in the parent satisfaction survey. 98% of families who participated in the satisfaction survey reported they were satisfied with the *KidsFirst* services they received from their home visitor.

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